NATIONAL PARTNERSHIP FOR ACTION
to End Health Disparities

Region X Health Equity Council Blueprint for Action

For more information about Region X Health Equity Council,
as well as list of current membership, visit
http://region10.npa-rhec.org/

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Introduction

The entire nation benefits when everyone has the opportunity and ability to live a long, healthy and productive life; however that ability is hampered when health disparities exist.[1]

A health disparity is a particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and economic obstacles to health and a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health, cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.[2]

Health disparities carry a high societal burden in terms of the loss of valuable resources, such as financial capital, healthy children and families, and workforce capacity.

Health equity is the attainment of the highest level of health for all people, achieving it requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[3]

Many of the underlying risk factors that contribute to health disparities and hamper equity are the result of where we live, learn, work and play, collectively known as the social determinants of health (SDH). The "social determinants of health are complex, integrated, and overlapping social structures and economic systems that include the social and physical environments, health services {systems}; structural and societal factors that are responsible for most health inequities. SDH are shaped by the distribution of money, power and resources at global, national, and local levels, which themselves are influenced by policy choices."[4]

Eliminating health disparities in the U.S. will demand behavioral, environmental, and social-level approaches to address issues such as insufficient education, inadequate housing, exposure to violence, and limited opportunities to earn a livable wage.[5]

The complexity and interconnectedness of health and social determinant disparities necessitate a coordinated multisectoral effort where government, community, civil society, public and private entities as well as individuals make a conscientious and continuous commitment to their eradication, as a living example of such an effort is the National Partnership for Action.

The National Partnership for Action

The National Partnership for Action to End Health Disparities (NPA) was established to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity.[6]

The vision for the NPA has been shaped by the voices of more than 2,000 individuals who shared their experiences and expertise through a series of regional conversations and meetings held by the U.S. Department of Health and Human Services (HHS) Office of Minority Health. The driving force of the NPA is the conviction that a nationally based strategy is needed—one that relies on multiple layers of partnerships across sectors in order to leverage resources and talent. The NPA is the first national, multisectoral, community and partnership-driven effort on behalf of health equity.

The mission of the NPA is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action.[7]

The National Stakeholder Strategy for Achieving Health Equity (NSS)

The NPA efforts culminated with the release of the National Stakeholder Strategy for Achieving Health Equity (NSS), which provides an overarching roadmap for eliminating health disparities through cooperative and strategic actions. The NSS was developed through a sequence of activities involving the collaboration of stakeholders from across the country.[8]

The goals of the NPA and its National Stakeholder Strategy for Achieving Health Equity are:

- Awareness - Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.
- Leadership - Strengthen and broaden leadership for addressing health disparities at all levels.
- Health System and Life Experience - Improve health and healthcare outcomes for racial, ethnic, and underserved populations.
- Cultural and Linguistic Competency - Improve cultural and linguistic competency and the diversity of the health-related workforce.
- Data, Research, and Evaluation - Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

Federal Interagency Health Equity Team

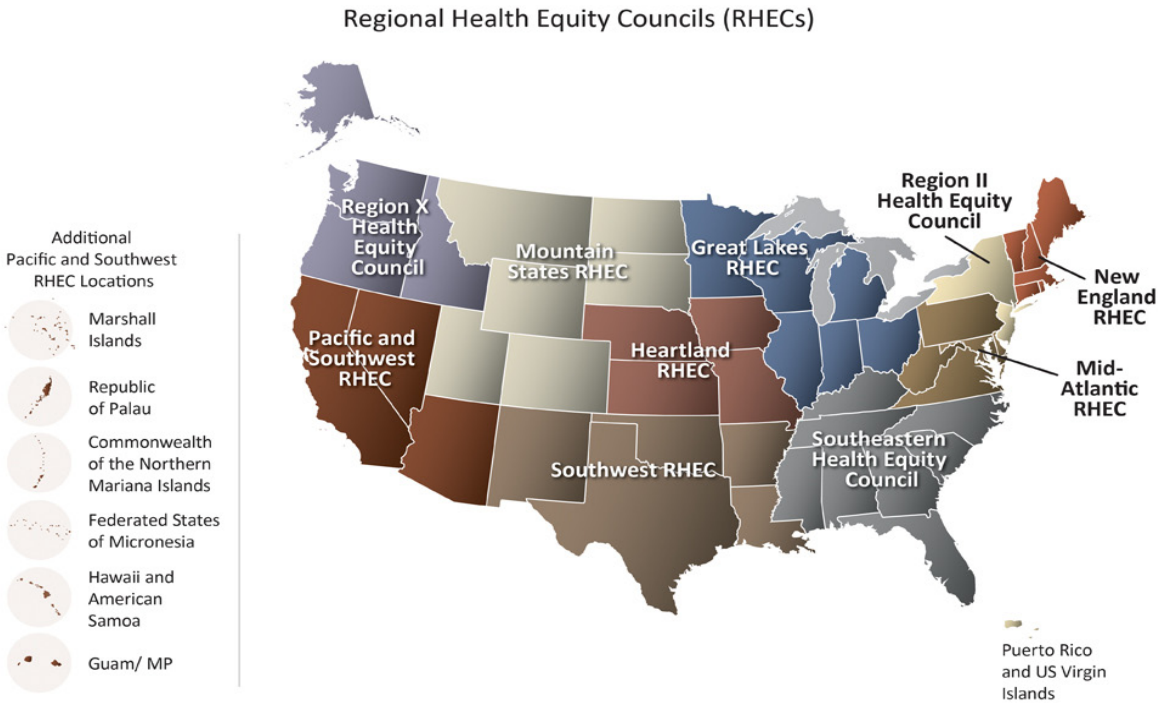
At the federal government level, leadership for the National Partnership for Action is provided by the Federal Interagency Health Equity Team (FIHET). Its mission is to foster communications and activities of the NPA within federal agencies and their partners; and, to increase the efficiency and effectiveness of policies and programs at the national, state, tribal, and local levels that work to end health disparities.[9]

FIHET members advance the objectives of the NPA based on its goals to:

- Unite around a national message.
- Collaborate around common goals.
- Leverage assets and experiences of partners.
- Identify opportunities for agency collaborations, partnerships, and communications that directly or indirectly impact NPA outcomes.
- Contribute to the NPA Regional Conversations, National Blueprint, and national efforts focused on the elimination of health disparities.
- Promote Federal participation in community strategies to end health disparities.
- Create opportunities to more systematically transition evidence-based findings to the field and expeditiously move them to practice and policy.
- Collaborate on guidance for community-level health disparities programs as a means for improving cohesion, implementation, and outcomes of programs funded by Federal agencies.
- Increase proactive use of technology in programs, services, and ancillary activities that address health disparities.

Regional Health Equity Councils

The NSS includes the formation of Regional Health Equity Councils (RHEC) with members who serve as leaders and catalysts to improve health equity in order to create sustainable growth and structure. The Regional Health Equity Councils (RHECs) are independent non-governmental organizations located in each of the ten U.S. Department of Health and Human Services' regions. Each council comprises leaders and stakeholders from both non-federal public and private sectors from within that region. Examples of sectors represented on the RHEC include academia, community based organizations, health systems, health insurers, state legislators, faith-based organizations, foundations, state government organizations, among others.



The RHECs' primary role is to initiate action to implement the goals of the NPA and therefore, advance the agenda to eliminate health disparities from the grassroots. The RHECs have been established to:[10]

- Identify key regional health inequity issues and drivers, and advance a responsive agenda.
- Use the collective power of organizations represented on the RHECs to derive models for and promote cross-sector collaboration.
- Initiate new and support existing regional policies and action to eliminate health disparities.
- Leverage opportunities available through organizations and sectors represented on the council to address health disparities.
- Convene regional stakeholders and partners to address regional health disparities issues.

Formed in each of the ten (10) HHS regions, the RHECs play a critical role in coordinating and enhancing state and local efforts to address health disparities and the social determinants of health. They also play a critical role in driving collective action at the regional level. Region X encompasses Alaska, Idaho, Oregon and Washington.

RHEC X: Purpose, Mission & Vision

Purpose

The Region X Health Equity Council (RHEC X) is a voluntary multi-sector group. Around the issue of health equity, the RHEC X provides leadership, ensures good communication, and facilitates regional actions to achieve our mission. We recognize that we play a key leadership role in implementing the National Stakeholder Strategy for Achieving Health Equity.[11]

The RHEC X functions independently to ensure that issues, strategies, and required actions are applicable to the states of Alaska, Idaho, Oregon and Washington. Our council:

- Works to raise the visibility of health disparities within the states of Alaska, Idaho, Oregon and Washington
- Works to increase capacity of communities to address social determinants of health by providing information, training, and resources
- Works to leverage available resources in support of our vision and mission
- Infuses the National Partnership for Action to End Health Disparities (NPA) goals and strategies into policies, practices within our groups and throughout our region
- Shares stories and successes with broad constituencies
- Hopes to build leadership, activism, and capacity within and between impacted communities
- Strives to ensure health occupational educational and career opportunities for underrepresented minority populations (URM's)

Mission

The RHEC X mission is to identify and use existing efforts and resources that target the elimination of health disparities, promote health equity and to educate and increase the awareness of the social determinants of health within the states of Alaska, Idaho, Oregon and Washington.

Vision

A nation free of health and healthcare disparities

RHEC X: Membership & Structure

Membership

Region X Health Equity Council members are individuals from the public (non-Federal employees) sector, private sector, communities, and community-based organizations. The council members serve as volunteers with the willingness to engage in actions to advance health equity and improve healthy living standards for the nation's most vulnerable populations. We intend that our member composition represent individuals and communities impacted by health inequities. The full RHEC X will review our member composition every year.[12]

Our members are racially and ethnically diverse; they work, live, or otherwise work on behalf of impacted communities. Most have engaged in relevant work on policies or programs that seek to eliminate health disparities or promote healthy living standards. Through its membership RHEC X seeks to host representatives who have knowledge of the issues faced by communities impacted by health disparities.[13] Regular meetings of the council occur on a bimonthly basis via teleconference. The Annual Meeting of the council must be in-person and is held in the latter part of each calendar year.[14]

Structure

The Council is comprised of up to eighteen (18) members in order to ensure appropriate representation of stakeholders within the region. Each member serves for a term of three (3) year(s), and for no more than two (2) terms.

Each of the ten regional health equity councils across the nation is guided by two co-chairs who also act as contacts and representatives to the Office for Minority Health and the Federal Interagency Health Equity Team (FIHET). Furthermore the co-chairs lead the efforts to identify and acquire support and resources for the activities of the council. The council co-chairs meet on a monthly basis to share knowledge, best practices, and to communicate about resources and activities that further the mission of the National Plan for Action.

The Co-Chairs for the RHEC X are:

- Jamie Lou Delavan, State Minority Health Coordinator and Cultural Liaison, Bureau of Community and Environmental Health, Division of Public Health, Idaho Department of Health and Welfare
- Benjamin Duncan, Chief Diversity and Equity Officer, Multnomah County Office of Diversity and Equity

RHEC X meets monthly, via conference call, for a general council meeting. This meeting is attended by all members with focused discussion on the action items for the coming month (e.g. if a workforce development item is identified, members interested commit to working on the task during the month and report back at the next monthly meeting). There are no committee or workgroup chairs. Each council member is able to choose to take the lead on a specific project in an area of interest as able. Projects are relevant to aspects of the National Plan for Action and the National Stakeholder Strategy and thereby further the goals of the RHEC.

The Annual Meeting of the Council is the single in-person meeting of the year and is typically held in the latter part of each calendar year.

Regional Blueprints for Action

The National Stakeholder Strategy (NSS) outlines the need to develop regional blueprints for action for each of the ten (10) HHS regions. The blueprints for action identify and present regional data, identify regional priorities, and outline regional strategies for achieving health equity. These blueprints for action embody the goals and priorities of the NSS but will also reflect regional priorities, maximize existing strengths and address existing gaps. The Blueprints will help guide the council's work to implement and monitor collaborative strategies that address the NPA's goals and to address health disparities within their region.

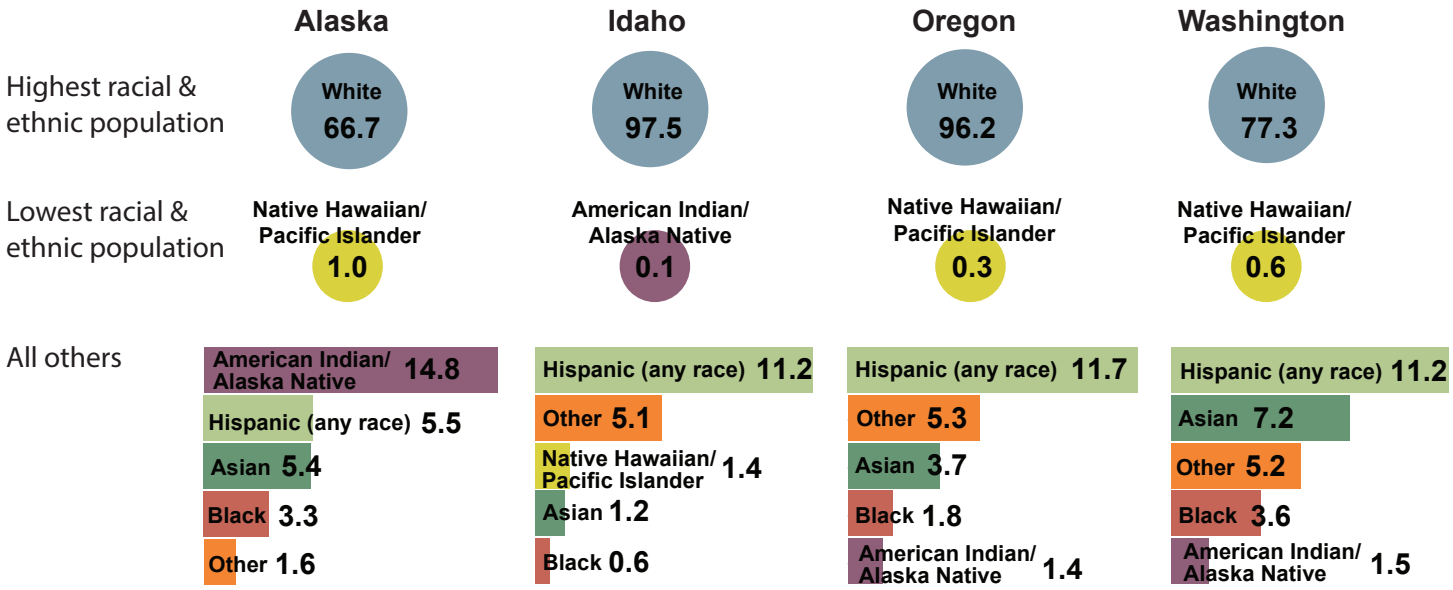
RHEC X members represent academia, state and local governments, public and private entities, faith-based/church organizations and other community groups from Alaska, Idaho, Oregon and Washington. Region X has developed this Blueprint for Action in order to present pertinent background information that will, as a first step, enable the region to further address health disparities and determinants of health with the aim to communicate council priorities and engage interested stakeholder at the federal, regional, state and community levels. The document will also serve as a starting point for the development of a health disparity scan of the region which will help identify priority areas for future research. The environmental scan will help in identifying specific issues that require the attention of the RHEC in Region X.[15]

Regional Context: Current Challenges and Strengths

The Region X Blueprint for Action embodies the goals and priorities of the NSS, as it also reflects the challenges faced by Region X as well as existing strengths. The blueprint seeks to represent Region X in terms of demographics, geographic distribution of resources, health and healthcare disparities, as well as selected social determinants of health of the states, tribes, communities and individuals within Alaska, Idaho, Oregon and Washington.

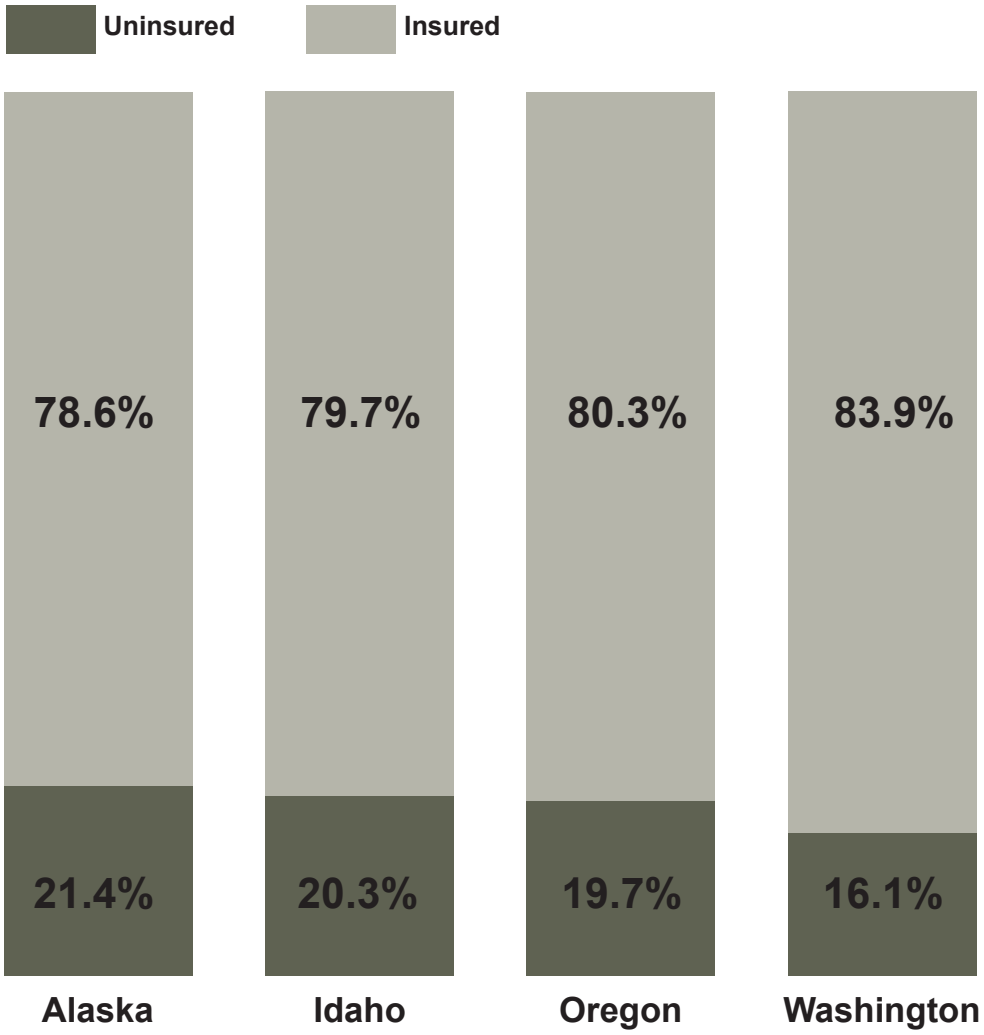
Demographics and Geographic Distribution within the Region

Percent Racial & Ethnic Population Composition in Region X States
Source: American Community Survey Fact Finder, 2010 Demographic Profile Data (1)



The demographic changes that are anticipated over the next decade magnify the importance of addressing health and healthcare disparities. Groups currently experiencing poorer health outcomes are expected to grow as a proportion of the total U.S. population; thus, the future health of America as a whole will be influenced substantially by our success in improving the health of all. Of the 12,833,427 individuals living in Region X states, 80% are White (only), 2.7% are Black (only), 5.3% are Asian,2.1% are Native American or Alaskan Natives, 0.6% are Native Hawaiian or Pacific Islander, 5.0% identify as other races. About 11% of the population identifies has Hispanic of any race.[16]

Uninsured Population by State, Region X
Source: United States Census - Small Area Health Insurance Estimates 2010 (2)



Over half of uninsured adults have no regular source of health care when they are sick. Worried about high medical bills, they are more than twice as likely to delay or forgo needed care as those who are insured.[17]

Health disparities in the United States are in part a result of disparities in insurance coverage, access, and quality of care.

The full implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 changed the manner in which access to health will be measured and addressed given its provision for health insurance marketplaces. However, until the ACA is fully implemented the insurance status of the population is the main indicator of access to health care in the U.S. In Region X, the uninsured rate oscillates between 21.4% in Alaska to 16.1% in Washington. The uninsured national average in 2010, was 16.3%. The uninsured are more likely to delay or forgo care which can lead to health problems, and increase the likelihood of hospitalization for avoidable conditions. The uninsured are also less likely than their insured counterparts to receive preventive care and services for major

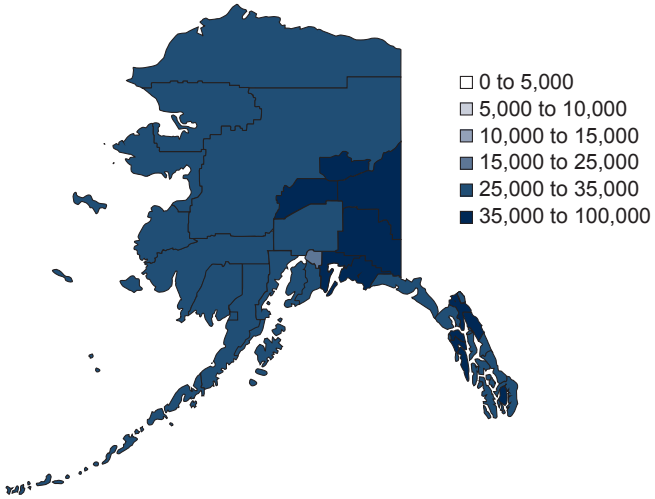
health condition like chronic disease and as a result suffer worse health outcomes. Research has demonstrated that extending coverage to the uninsured improves physical and mental health, reduces mortality rates, and ameliorates financial strain associated with health care costs.[18]

Millions of uninsured Americans became newly eligible for coverage made available by the Affordable Care Act, a conservative estimate of the number of those newly eligible in Region X by state and county is depicted in the following maps:

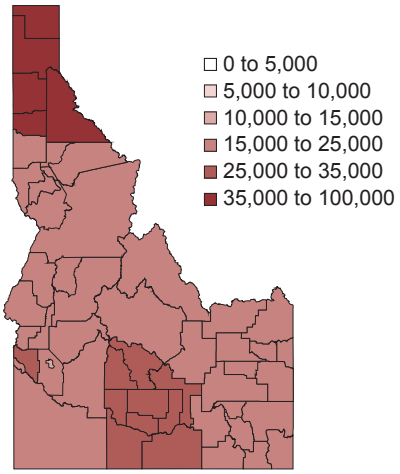
Uninsured populations eligible for coverage in Region X by State
Total Nonelderly (Aged 0-64) Uninsured in Each Area,
Source; Enroll America, 2013 (3)

Note: CMS and ASPE used the Census Bureau's 2011 American Community Survey (ACS) for the analysis. All estimates represent the eligible uninsured population aged 0-64 and have been adjusted by ASPE to account for eligibility due to immigration status. The maps show the distribution of the uninsured by combining US Census "public use micro-data areas" (PUMAS) and data from Centers for Medicare and Medicaid Services (CMS)

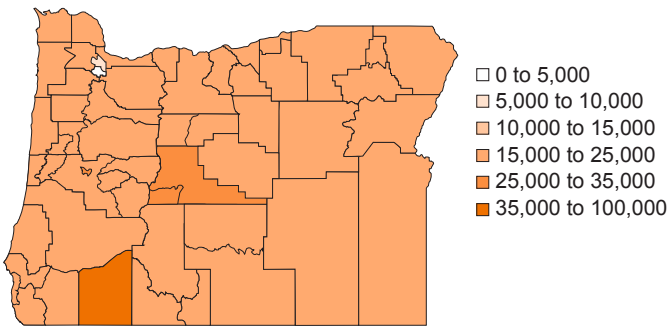
Alaska



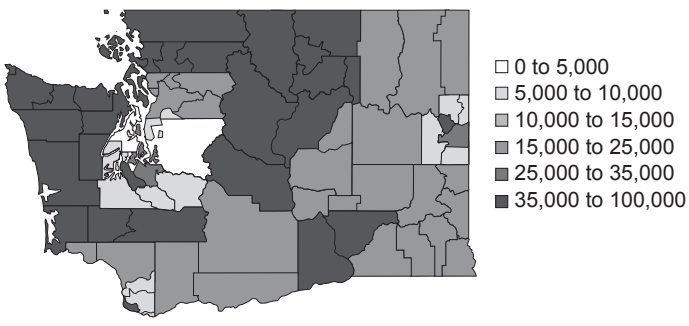
Idaho



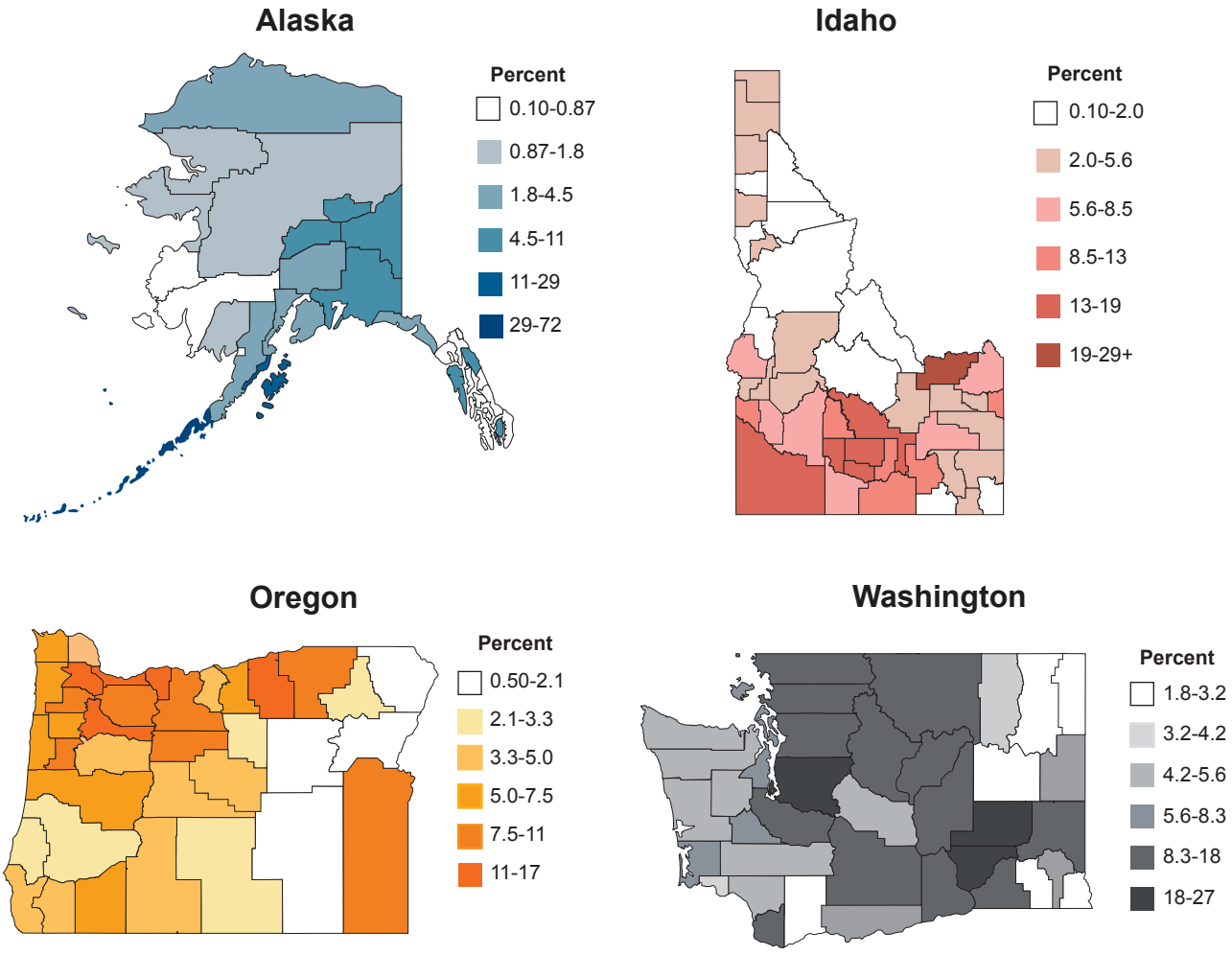
Oregon



Washington



Region X Medically Underserved Areas and Population by State
Source: Agency for Healthcare Research and Quality -HRSA Data Warehouse, Health Professional Shortage Areas (HPSA) and Medically Underserved Areas / Populations (MUA/P) (4)



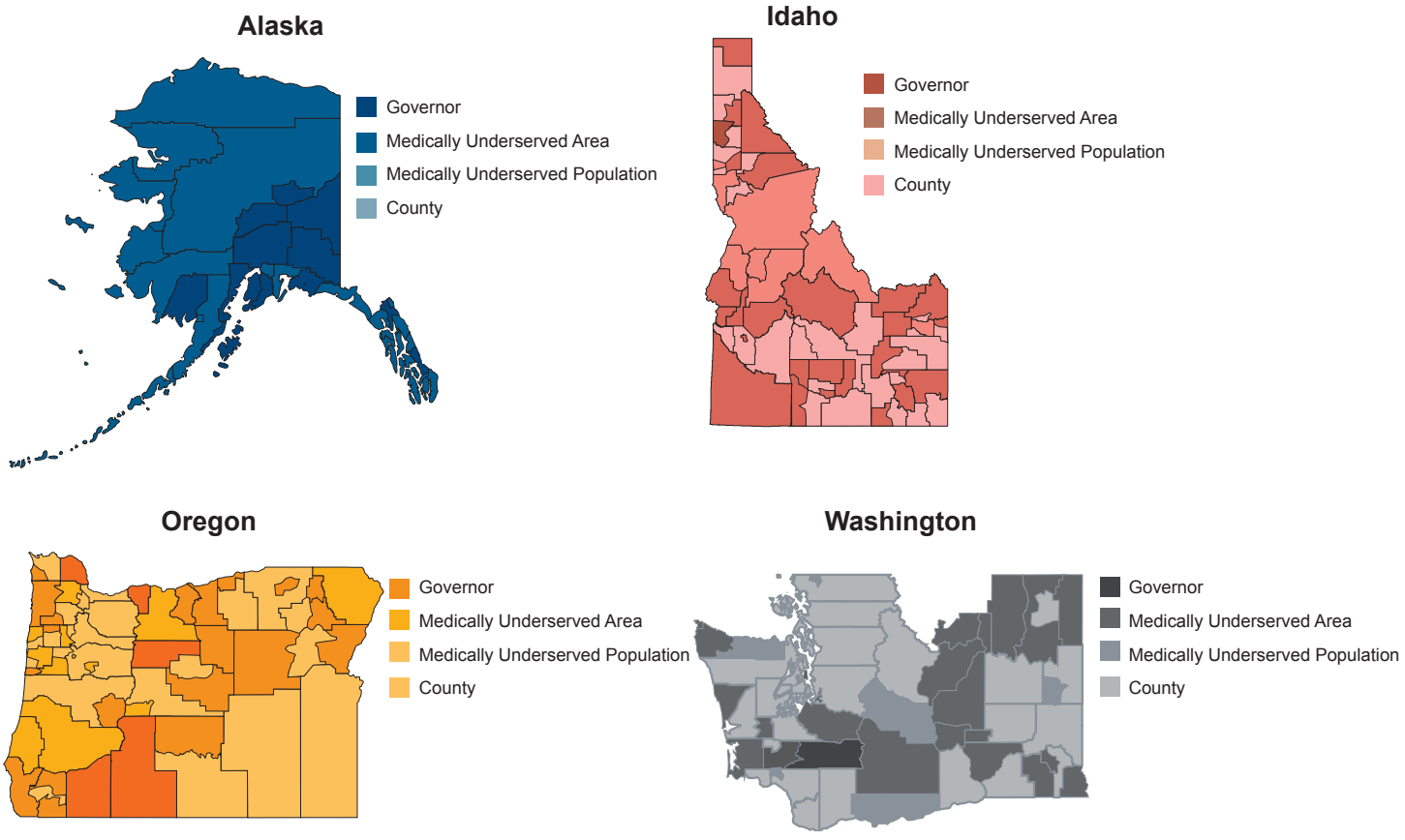
Even when health insurance is obtained there are other obstacles to access healthcare. The availability of primary care physicians and providers, as well as dental and mental health services also play a role in health disparities. Medically Underserved Areas (MUAs) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.[19]

Furthermore, Medically Underserved Areas/Populations (MUA/Ps) are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or a large elderly population.[20]

Region X has numerous HHS designated MUAs. The MUAs lack mental, dental and medical primary care professionals which limit the access of the population to proper care and place an additional burden on disease management for those with chronic conditions.

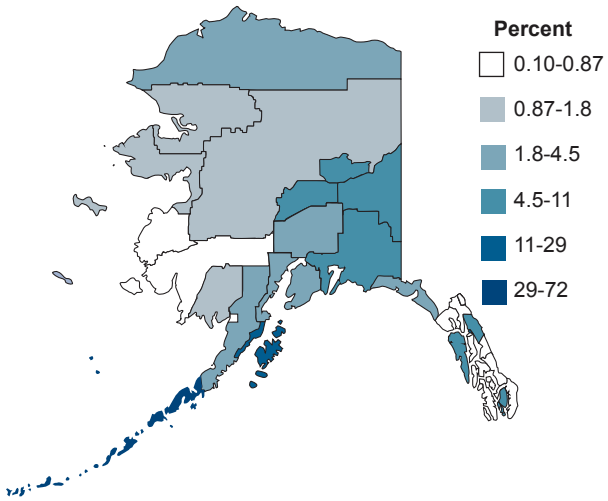
A governor's Medically Underserved Population (MUP) designation is a type of MUP that addresses special circumstances. Under the provisions of Public law 99-280, enacted in 1986, a population group that does not meet the established criteria of an Index of Medical Underservice (IMU) less than 62.0 can be considered for designation if "unusual local conditions which are a barrier to access, or the availability of personal health services exist and are documented" and if such a designation is recommended by the chief executive officer and local officials of the state where the requested population resides. These areas are not eligible for Rural Health Clinic (RHC) certification.

Region X Medically Underserved Areas and Population by State

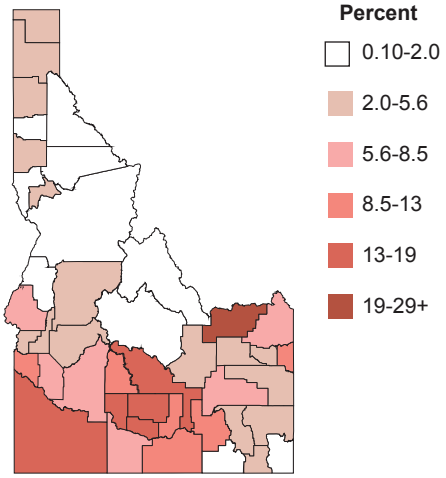


Foreign-Born Population by Region X State Trend Over Time, 2006-2010 - Source: Index Mundi from American Community Survey U. S. Census Bureau, American Community Survey, 5-Year Estimates. (5)

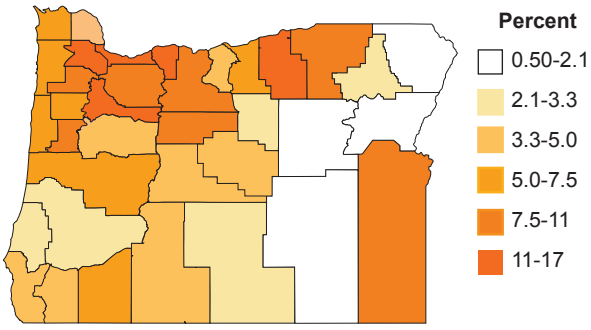
Alaska



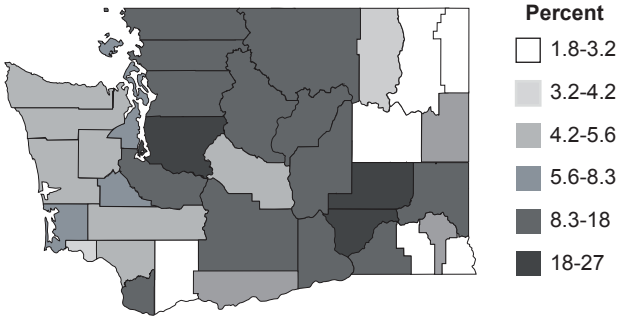
Idaho



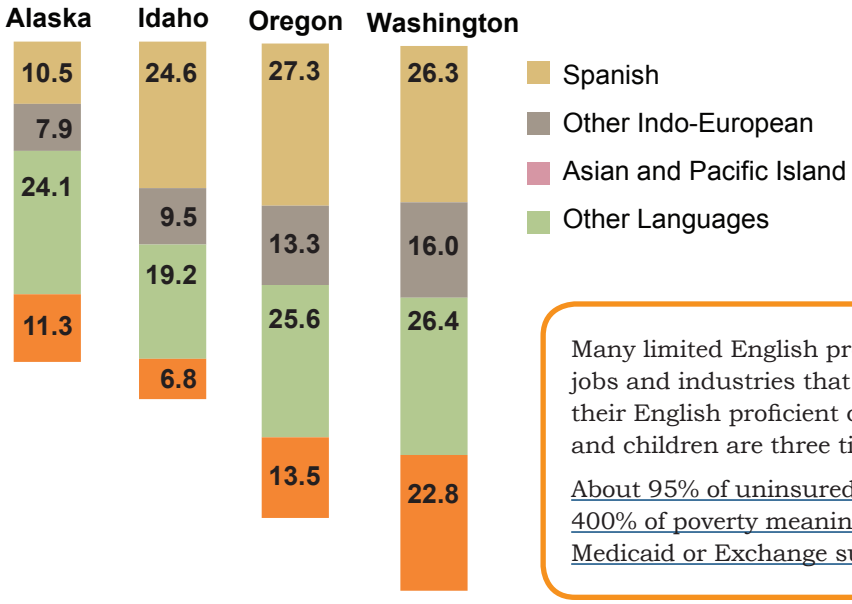
Oregon



Washington



Linguistic Isolation in Region X States, Source 2005-2009 American Community Survey 5-Year Estimates S1602 (6)



Many limited English proficiency populations (LEP) are in low wage jobs and industries that do not offer health coverage. Compared to their English proficient counterparts LEP adults are half as likely and children are three times less likely to have private coverage.

About 95% of uninsured individuals with LEP have incomes below 400% of poverty meaning that they will be income-eligible for Medicaid or Exchange subsidies in 2014. [25]

Language and cultural barriers hinder the attainment or restoration of health in certain population groups, even when health care resources are geographically available. In terms of health disparities language barriers may compound and exacerbate other barriers to care like being uninsured and residing in a medically underserved area. For example, the rate of foreign- born without health insurance is more than double that of the native-born.[21] The concept of "linguistic isolation" was developed by the U.S. Census (1990) in order to enumerate and identify the characteristics of those households which might need assistance to communicate with the government and its agencies given that it may be a barrier to the receipt of medical and social services. Linguistic isolation is dependent on the English-speaking ability of all adults in a household (14+ years of age), and for a household to be designated as "linguistically isolated" all adults speak a language other than English and none speak English "very well".[22] In Region X more than a quarter of households who speak Spanish or an Asian and Pacific Island language experience linguistic isolation. Tactics to strengthen communication and foster positive relationships between patients and providers include the use of medical interpretation services, the racial and ethnic diversification of the healthcare workforce and development and implementation of provider training programs and tools for cultural competency.

Health care that is linguistically appropriate is part of cultural competency, which is one of the main ingredients in closing the disparities gap in health care. The Office of Minority Health within the U.S. Department of Health and Human Services has developed a series of initiatives and tools to aid in the pursuit of cultural competency. For example, The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) were developed to provide a blueprint for health and healthcare organizations to provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse

cultural health beliefs and practices, preferred languages, health literacy and other communication needs.[23]

Numerous studies have shown that racial and ethnic minority practitioners are more likely to practice in medically underserved areas and provide health care to large numbers of racial and ethnic minorities who are uninsured and underinsured. Through the inherent cultural competency that a more diverse workforce would possess, these professionals can help improve access and adherence to treatments.[24]

In all, health care services that are respectful and responsive to health beliefs, practices and the cultural and linguistic needs of diverse patients can help bring about positive health outcomes for all.

Disparities in Health Outcomes

Health disparities avoidable and unjust, therefore ensuring greater equity and accountability of the health care system is important to the constituency, public and private health plans as well as health care providers.[26]

To this end, the annual Agency for Healthcare Research and Quality (AHRQ) National Health Disparities Reports (NHDR) have documented the status of healthcare disparities and quality of care received by racial, ethnic and socio-economic groups in the United States. The NHDR documented that racial and ethnic minorities often receive poorer quality of care and face more barriers in seeking care including preventive care, acute treatment, or chronic disease management, than do non-Hispanic White patients.[27]

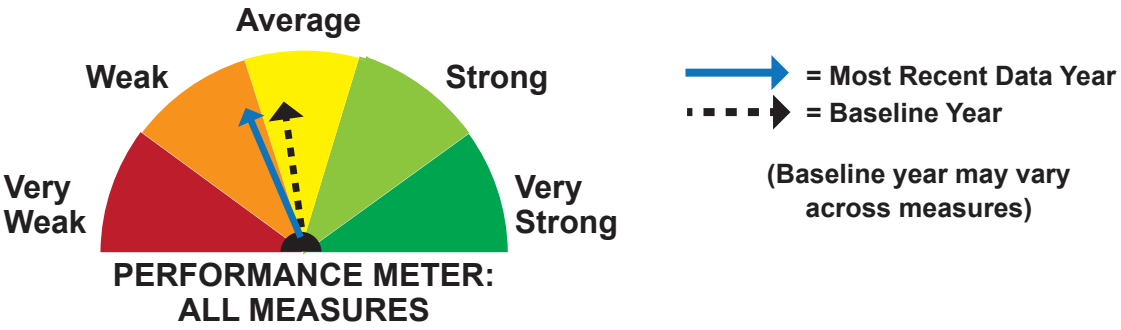
The National Healthcare Quality Report (NHQR), produced by the Agency for Healthcare Research and Quality (AHRQ), provides information on quality performance measures across types of care (preventive, acute and chronic), healthcare settings (hospital, ambulatory, nursing home, and home health), treatment and management of five clinical conditions (cancer diabetes, heart disease, maternal and child health as well as respiratory diseases) as well as specialty focuses (diabetes, asthma, clinical preventive services, disparities, payer and variation over time).

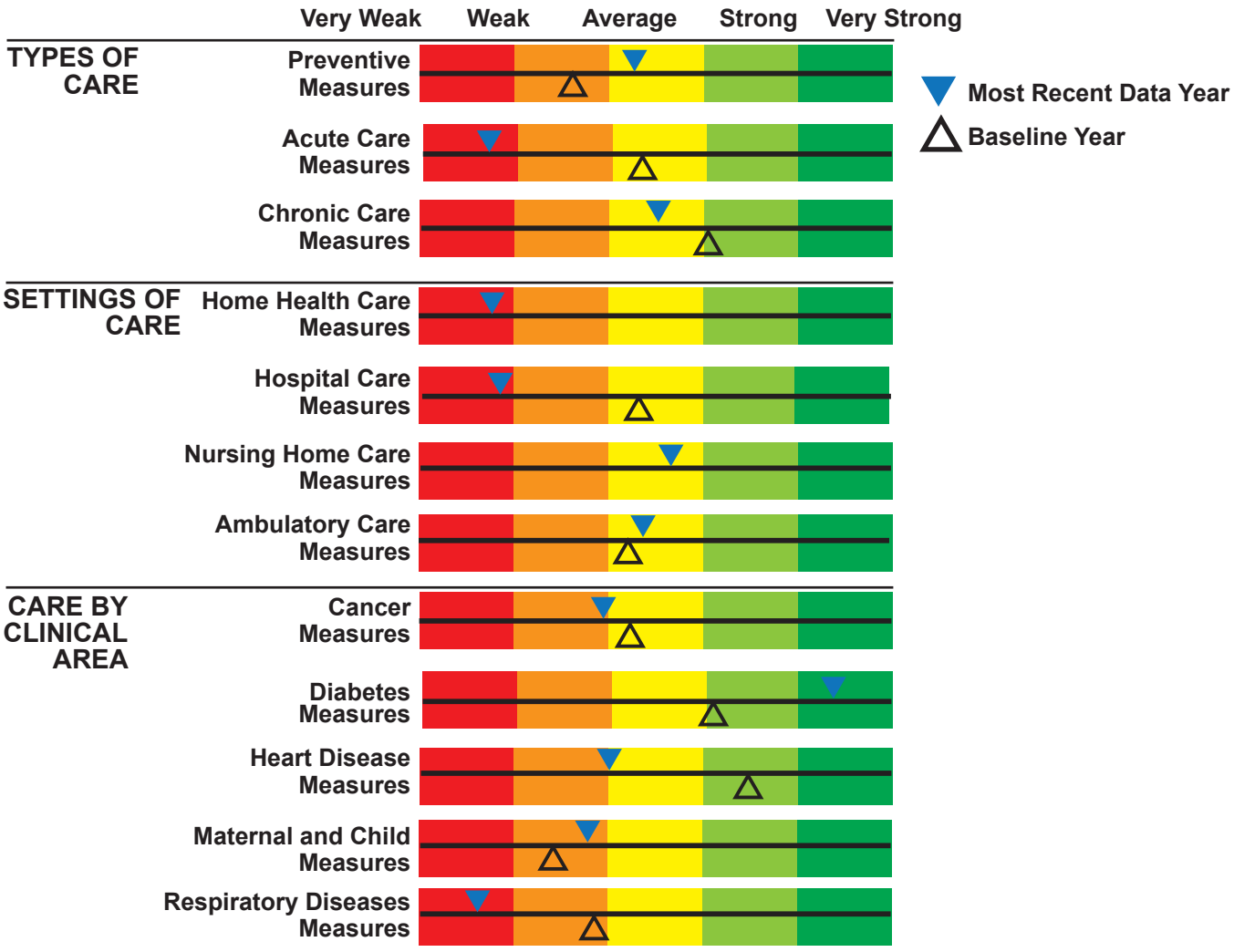
The 2010 State Snapshots (Health Resource and Services Administration -HRSA) summarizes state-specific health care quality information and performance from the NHRQ and compares the data to national averages. The Region X overall quality report is presented here by state compared to the national average and their respective baseline years along with strengths and weaknesses.

Overall, Region X states have seen a decline in the healthcare quality measures of performance compared to their respective baseline years. Alaska has experienced a sharp deterioration in acute care, hospital care and respiratory measures of quality. Idaho has also seen marked declines in quality measures among maternal and childcare as well as respiratory disease measures. Oregon and Washington have maintained a relatively stable performance compared to their baseline years with the most pronounced decline found in preventive health measures.

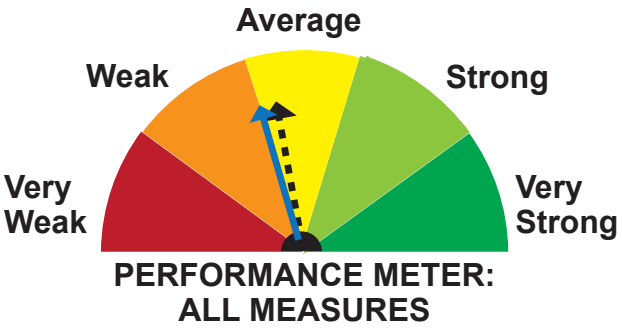
Overall Health Care Quality Region X
Source: Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality Report (NHRQ) (7)

Alaska: Overall Healthcare Quality





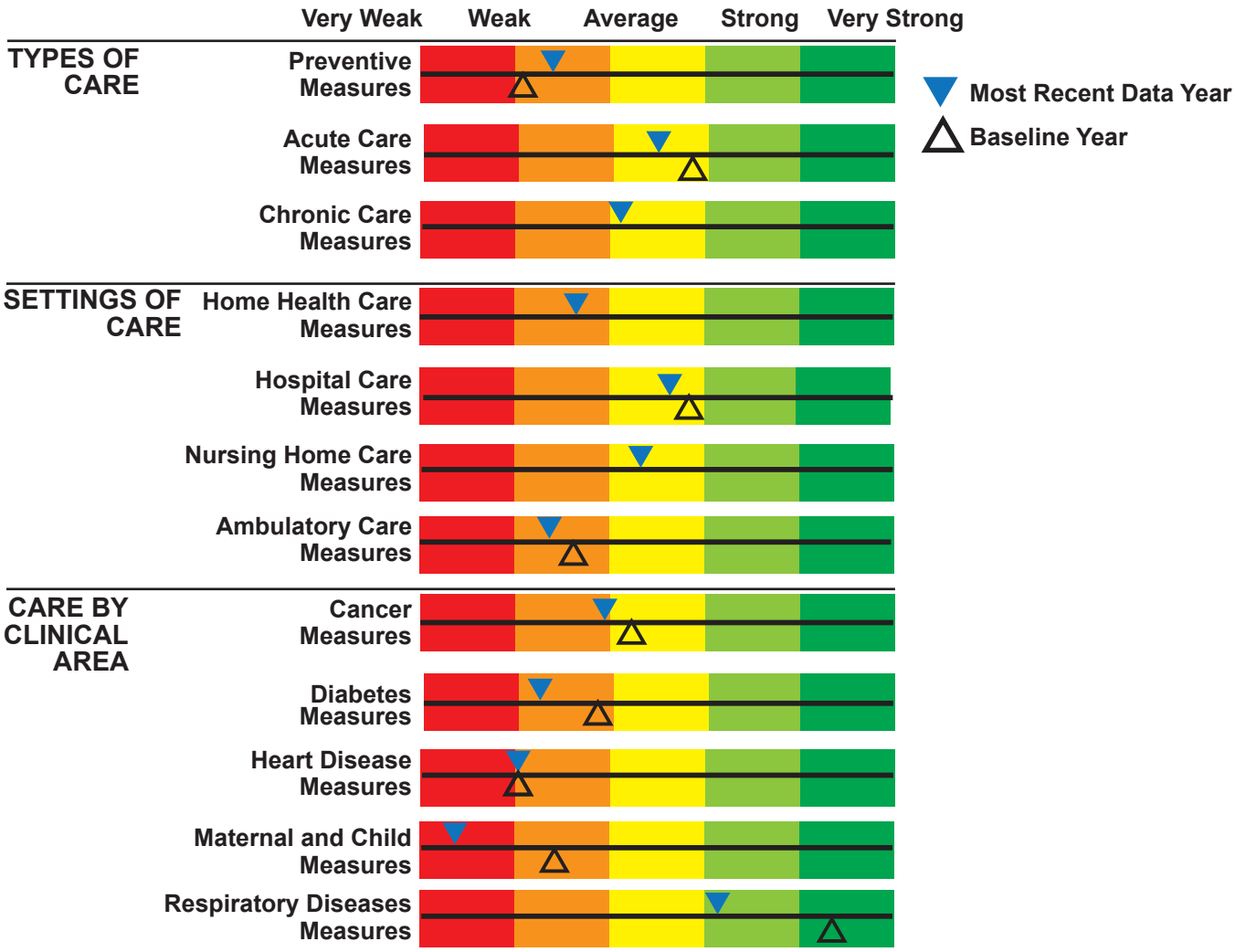
Idaho: Overall Healthcare Quality



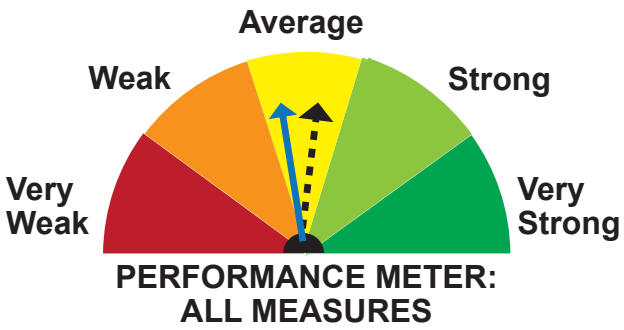
PERFORMANCE METER: ALL MEASURES

= Most Recent Data Year
= Baseline Year

(Baseline year may vary across measures)



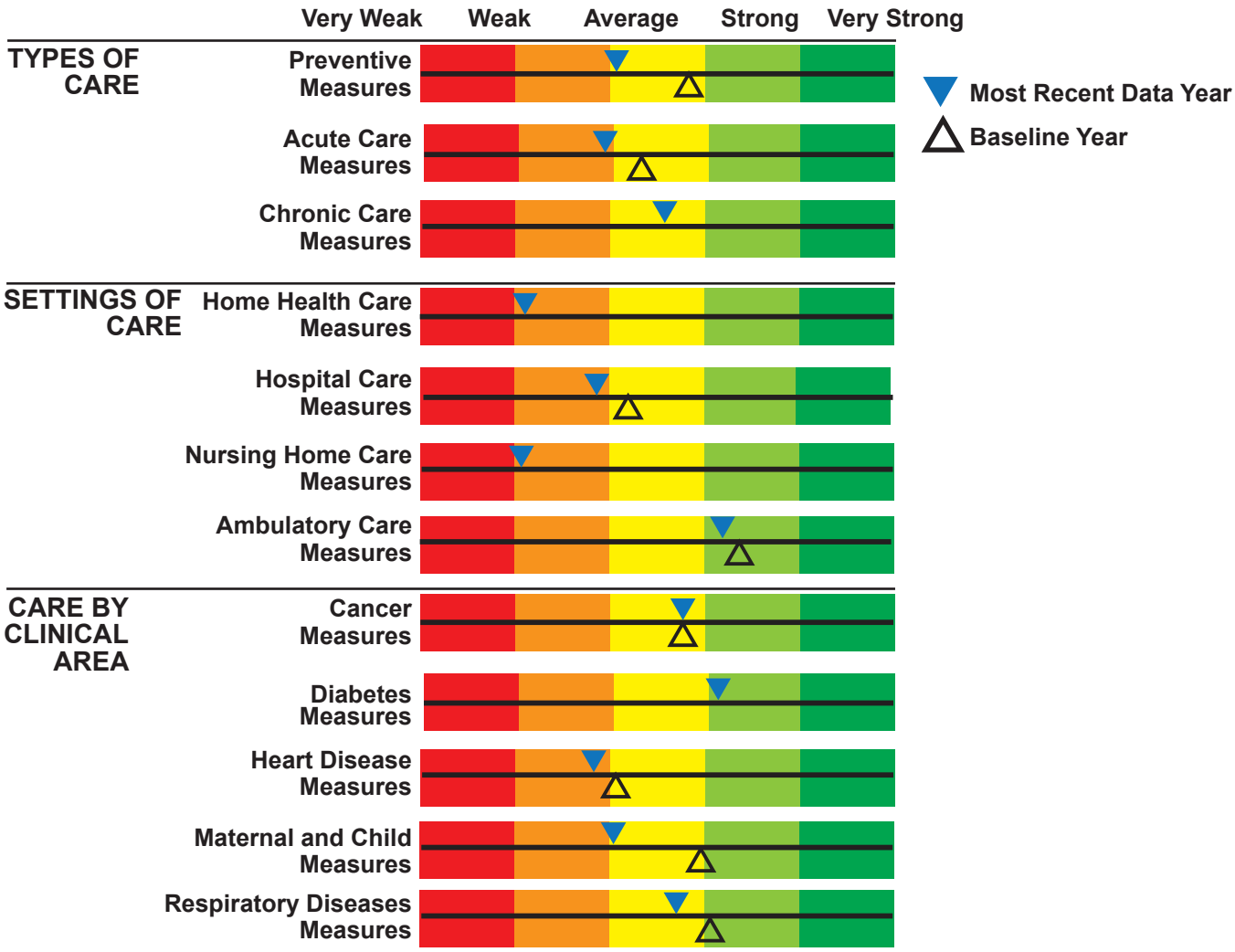
Oregon: Overall Healthcare Quality



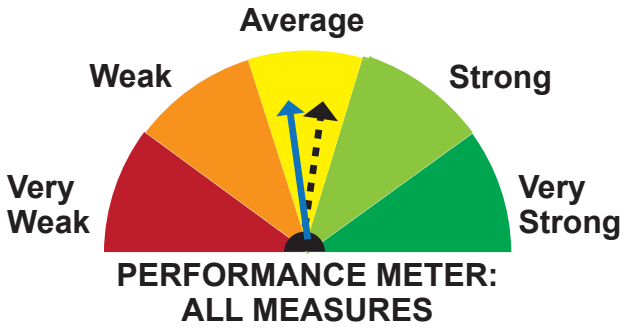
PERFORMANCE METER: ALL MEASURES

= Most Recent Data Year
= Baseline Year

(Baseline year may vary across measures)

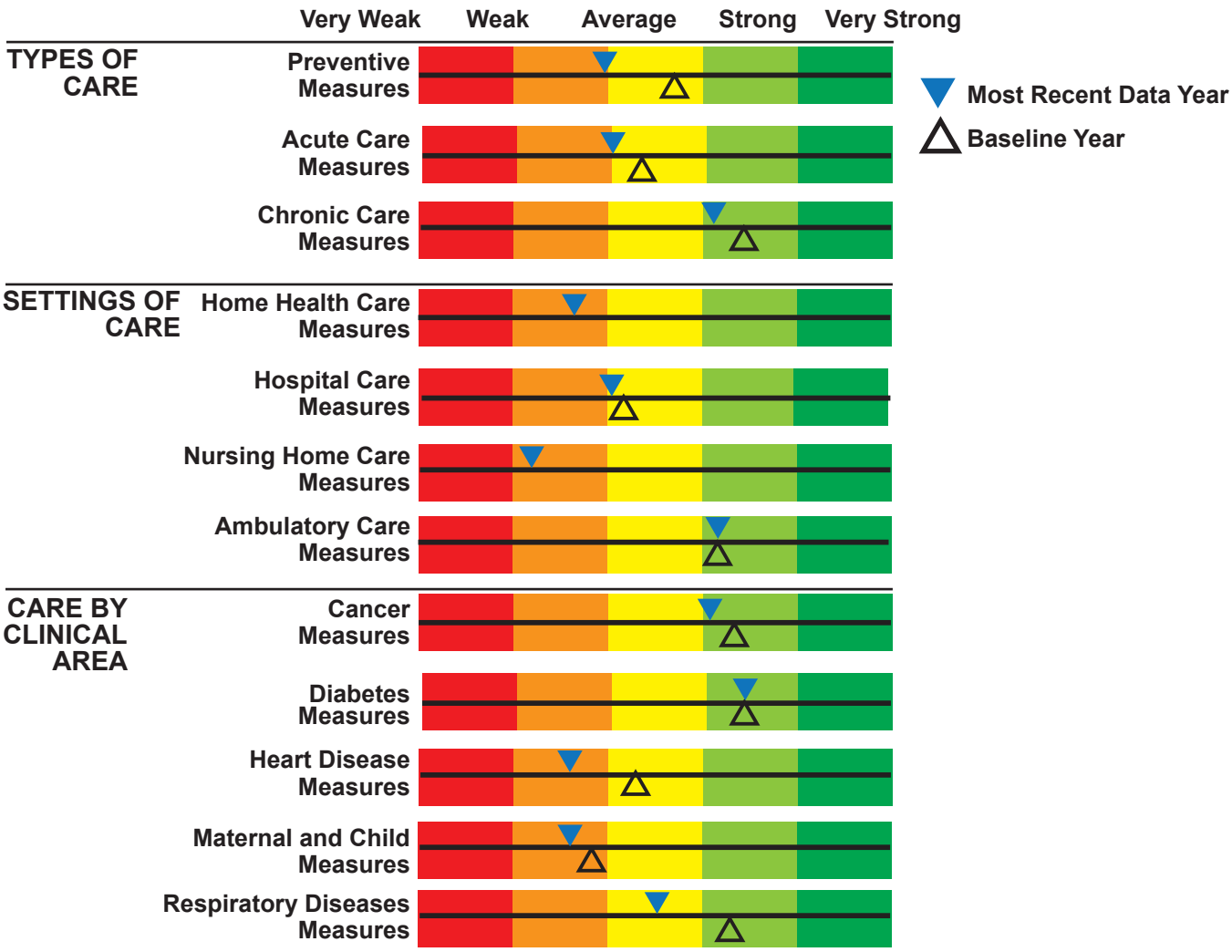


Washington: Overall Healthcare Quality



= Most Recent Data Year
= Baseline Year

(Baseline year may vary across measures)



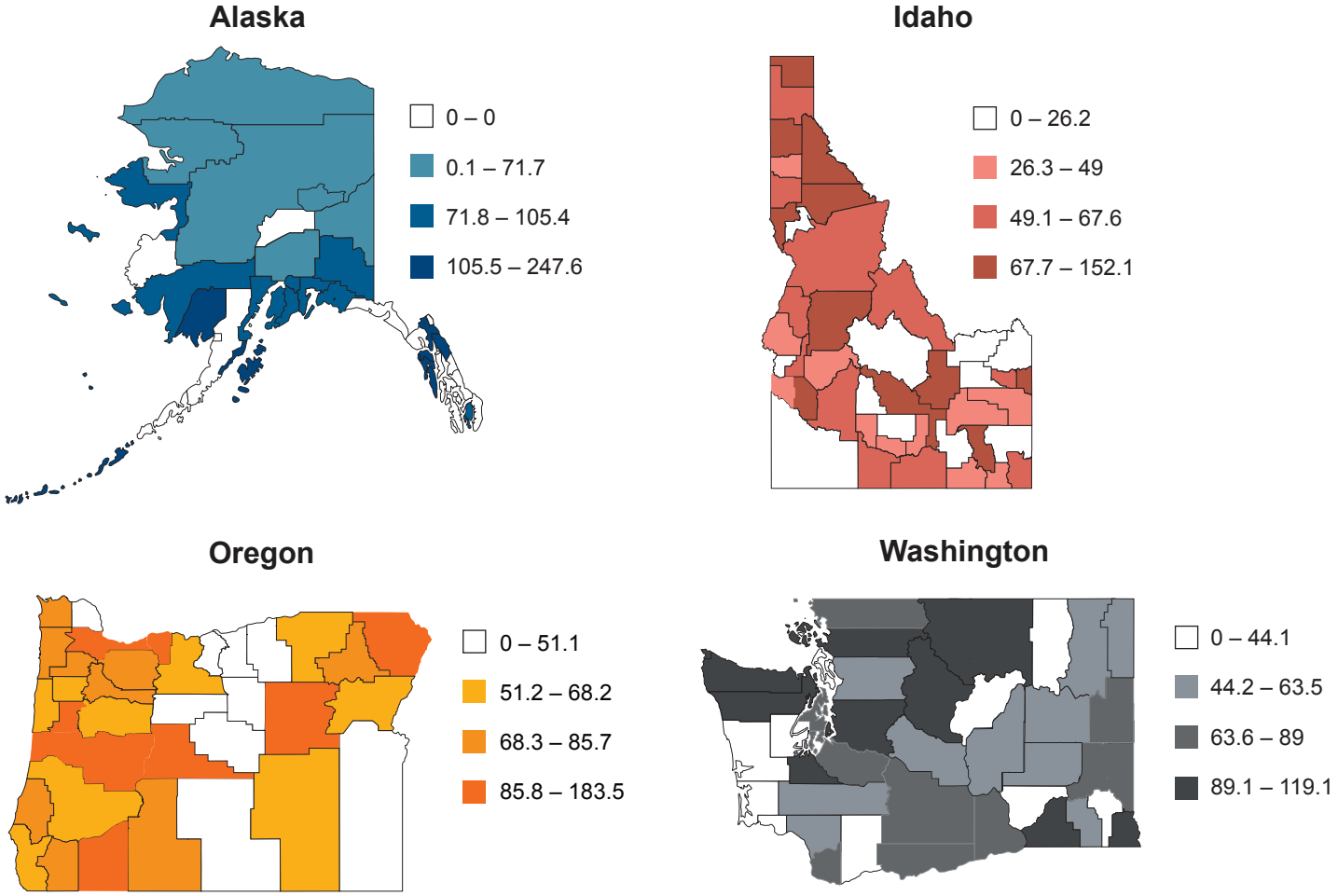
Primary Care

Access to primary quality care has been identified as one of the mechanisms through which racial and ethnic disparities in health might be reduced. Members of racial and ethnic minority groups are overrepresented among the 56 million people in America who have inadequate access to a primary care physician. Minority children are also less likely than non-Hispanic White children to have a usual source of care. Adequate primary care can address the health problems that people have most of the time. The greatest benefits of primary care come to poor and socially disadvantaged groups, though all benefit.[29] The following maps show the geographic distribution of primary care physician providers in Region X as well as that of nurse practitioners and registered nurses who comprise the primary care team.

Region X: Access to Primary Care Providers within State – Source: Health Resources and Services Administration (HRSA)

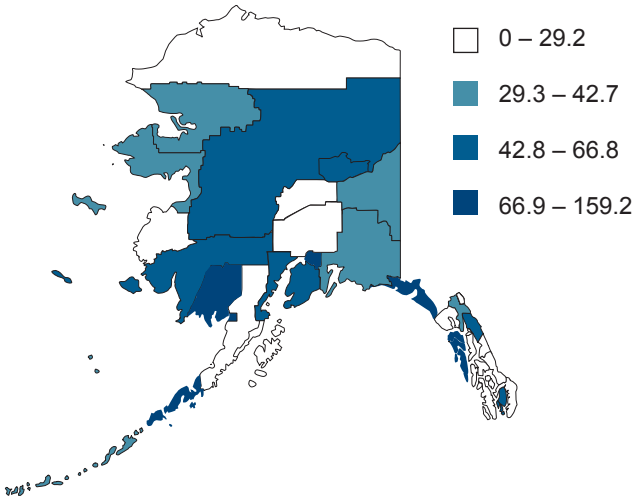
State Primary Care Physicians per 100,000 pop., 2010 (8)

Primary care physicians include medical doctors who identified as having a general practice, family medicine, general internal medicine, or general pediatrics (HRSA). They are usually the first point of contact for people who have access to the formal health care system in the U.S. Thus, their availability is of importance to not only detect disease and illness but to manage it as well.

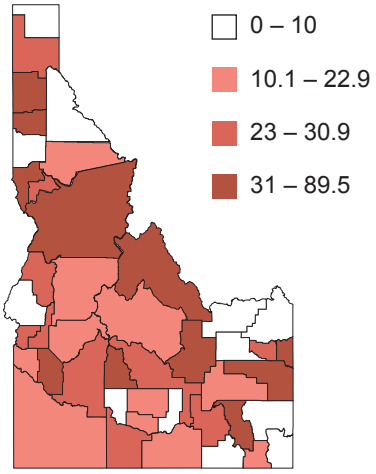


State Nurse Practitioner Provider per 100,000 population, 2010 (9)

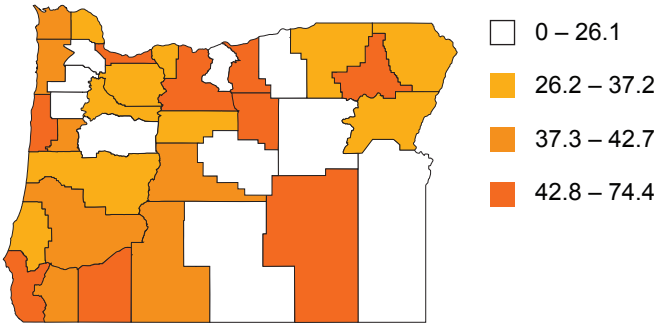
Alaska



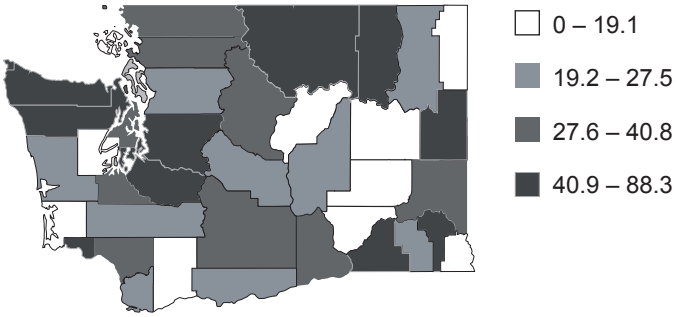
Idaho



Oregon

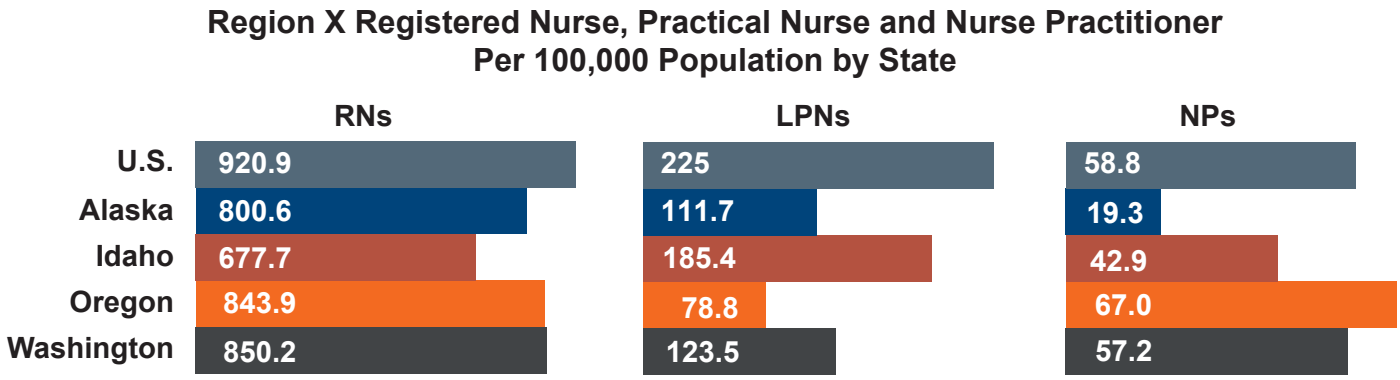


Washington



HRSA identifies a nurse practitioner as a registered nurse provider with a graduate degree in nursing prepared for advanced practice involving independent and interdependent decision making and direct account inability for clinical judgment across the health care continuum or in a certified specialty. The tasks of nurse practitioners are dictated by geographic, political, economic, and social factors. However their role in the disease detection and management is increasing nationwide.

Region X Registered Nurse (RN), Practical Nurse (PN) and Nurse Practitioner (NP) per 100,000 population by State
Source: (a) The U.S. Nursing Workforce Trends in Supply and Education, Health Resources and Services Administration- Bureau of Health Professionals- National Center for Health Workforce Analysis 2013; (b) The Henry J. Kaiser Family Foundation 2011, KFF Total Nurse Practitioner (10).



Note from KFF: The 2011 Pearson Report, The American Journal for Nurse Practitioners, NP Communications LLC. The complete state-by-state NP legislation/regulation summary and analysis is available at www.webnponline.com.

Although A 2010 HRSA study found that the nursing workforce is growing and becoming more diverse, the states in Region X have a lower number of registered nurses per 100,000 than that of the national average.[30]

Nurses in all settings are strategically positioned to identify needs for social services and push healthcare and public health agencies to address these needs.[31]

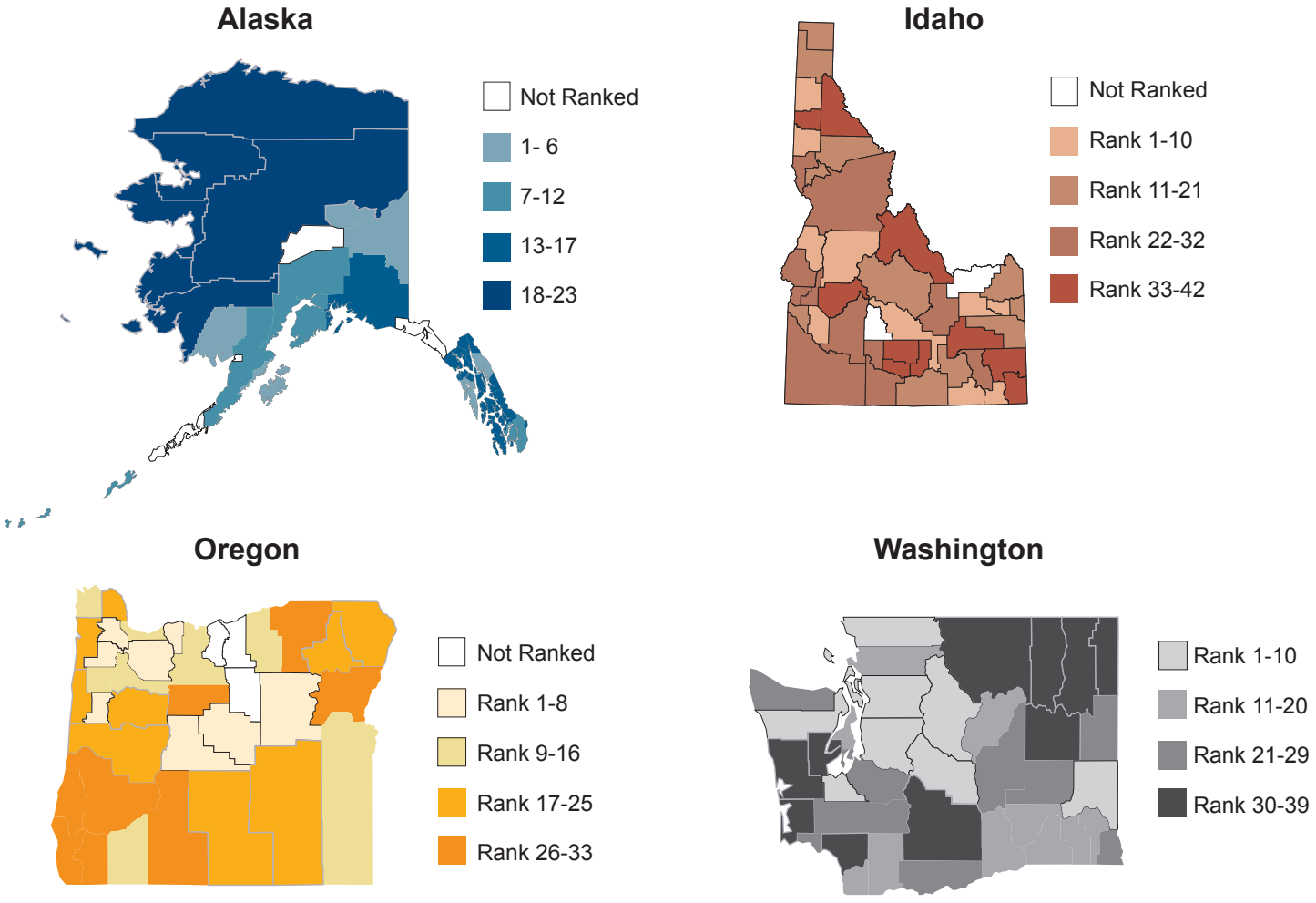
Innately, nursing is a profession for which relationships are central and nursing can promote nurse-managed primary care and focus on changing and supporting local state and national policies that increase access and equity.[32]

The Surgeon General, through the National Prevention Strategy, delineates the will of the federal government to support and expand training programs that bring new and diverse workers into health care and public health workforce and support health center service delivery sites in medically underserved areas and place primary care providers in communities with shortages.[28]

Health outcomes, like length and quality of life, vary within and among states in Region X as a result of differences in determinants of health, such as heath behaviors, clinical care access, social, economic and physical environment factors. Stakeholders, public or private, must have an acute awareness of the resources that communities have in order to appropriately address their particular health needs.[33]

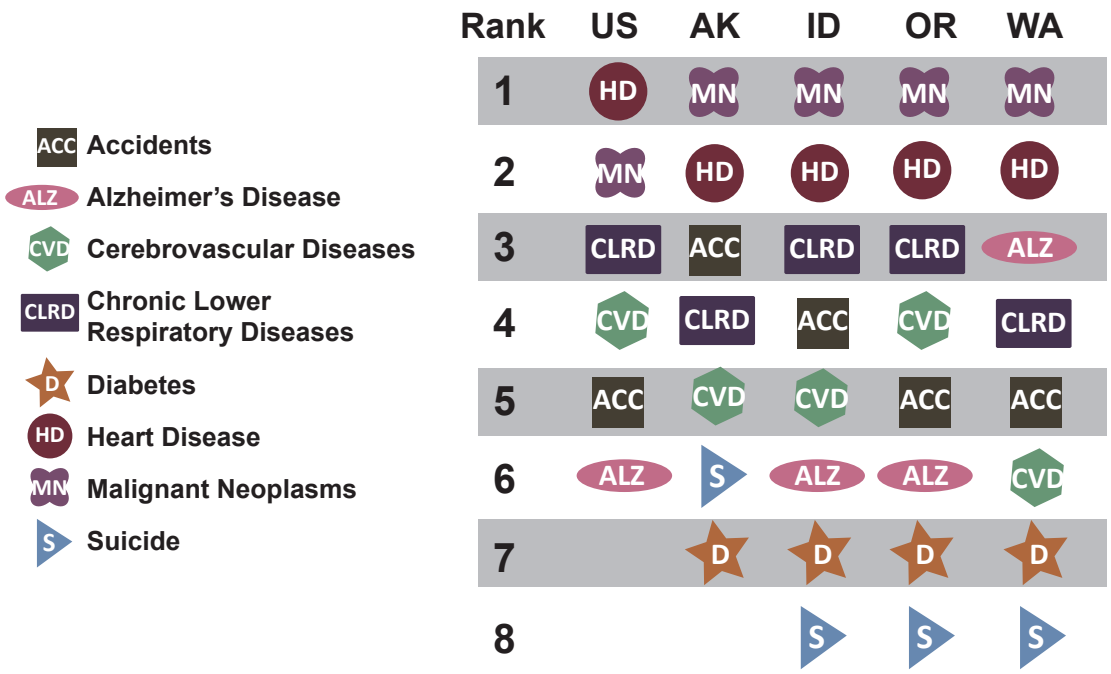
County Health Rankings on Health Outcomes within Region X States
Source: Robert Wood Johnson Foundation 'County Health Rankings,' 2013 (11)

(The lowest score (best health) gets a rank of #1 for that state and the highest score (worst health) gets whatever rank corresponds to the number of units ranked in that state.)



Accidents (unintentional injuries) figure in the top five (5) causes in Region X. Accidents and unintentional injuries include motor vehicle accidents, water air and space accidents, poisoning and exposure to noxious substances, smoke, fire and flames as well as drowning and falls. These types of accidents are amenable to public health interventions.[34]

Modified data: Rank Mortality Rates by Cause Region X States / 100, 000
Source: CDC LCWK9 2010 (12)



Deaths, percent of total deaths, percent of total deaths, and death rates for the 15 leading causes of death: United States, Source: CDC LCWK9. Deaths, percent of total deaths, and death rates for the 15 leading causes of death: United States and each State, 2010 (11)

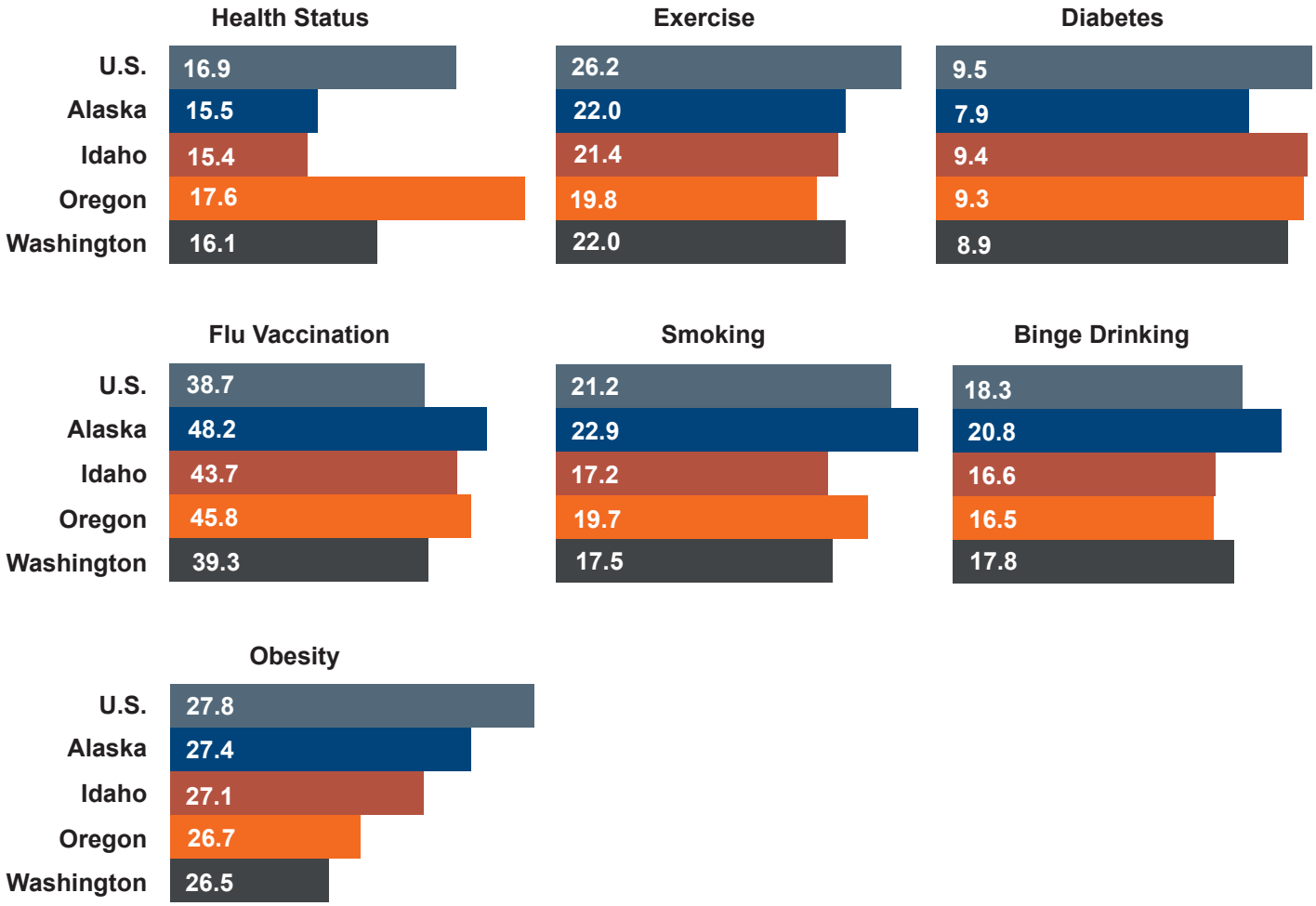
Just as social and system level influences like health care access and the quality of medical care can exacerbate health disparities, so too can risk behaviors. Behavioral risk factors, such as tobacco smoking, physical inactivity, and poor diet choices (although at times due to unavailability of nutritious food) are also disparately found in and among the populations of each of the Region X states. Research studies have elucidated on disparities across a range of chronic conditions, including cardiovascular disease, respiratory diseases, diabetes, cancers as well as musculoskeletal, conditions.[35]

The Selected Metropolitan/Micropolitan Area Risk Trends (SMART) project uses the Behavioral Risk Factor Surveillance System (BRFSS) to analyze the data of selected metropolitan and micropolitan statistical areas (MMSAs) with 500 or more respondents. These data can be used to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Information was obtained regarding the percentage of adults reporting on selected health risks nation and statewide regarding the following risk factors:[36]

- Health Status - Percentage of adults reporting general health as fair or poor
- Exercise - Percentage of adults reporting doing no leisure time exercise or physical activity in the past 30 days
- Diabetes - Percentage of adults told by doctor they have diabetes
- Flu Vaccination - Percentage of adults aged 65 or older reporting not having had a flu shot within the past 12 months
- Current Smoking - Percentage of adults reporting having smoked at least 100 cigarettes in their lifetime and currently smoke
- Binge Drinking - Binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion)
- Obesity- Percentage of adults reporting a body mass index greater than or equal to 30

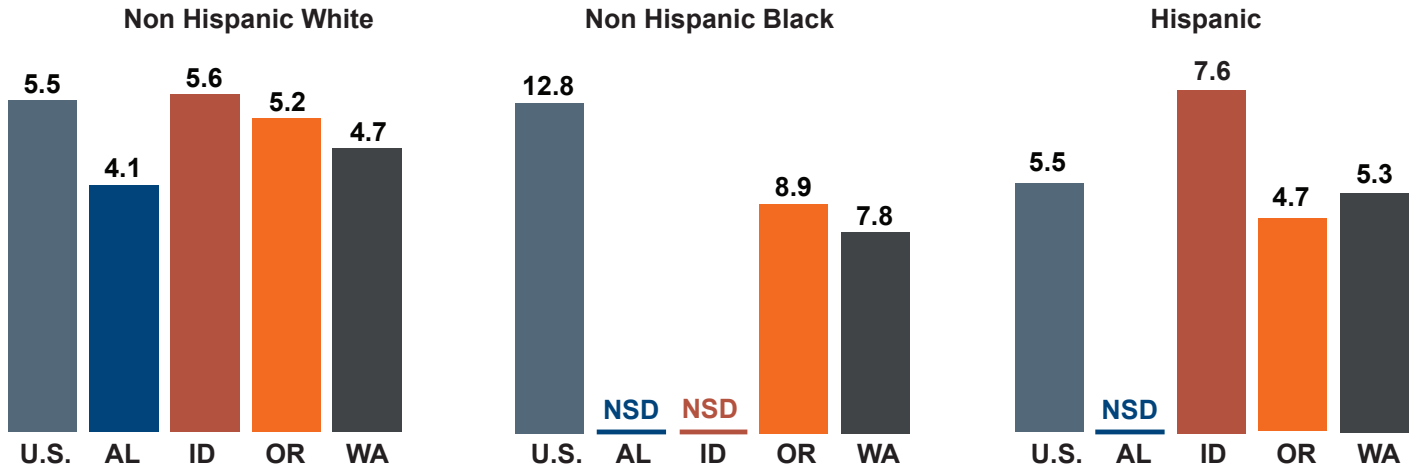
Percent of US and Region X State Adults Reporting Selected Health Risk
Source: SMART BRFSS (Selected Metropolitan/Micropolitan Area * Risk Trends from the Behavioral Risk Factor Surveillance System (BRFSS), 2011 (13)

Table: Region X by State: Percentage of adults reporting on selected health risks- adapted from SMART BRFSS Data



At the national level, large disparities in infant mortality rates disproportionately affect racial and ethnic minority populations and have even increased demonstrating that not all racial and ethnic groups have benefited equally from social and medical advances. For example, infants that are born to Black women are 1.5 to 3 times more likely to die than infants born to women of other races / ethnicities.[37] American Indian/Alaska Natives have 1.6 times the infant mortality rate as non-Hispanic Whites and the rate for Native Hawaiians is 1.7 than for non-Hispanic Whites.[38]

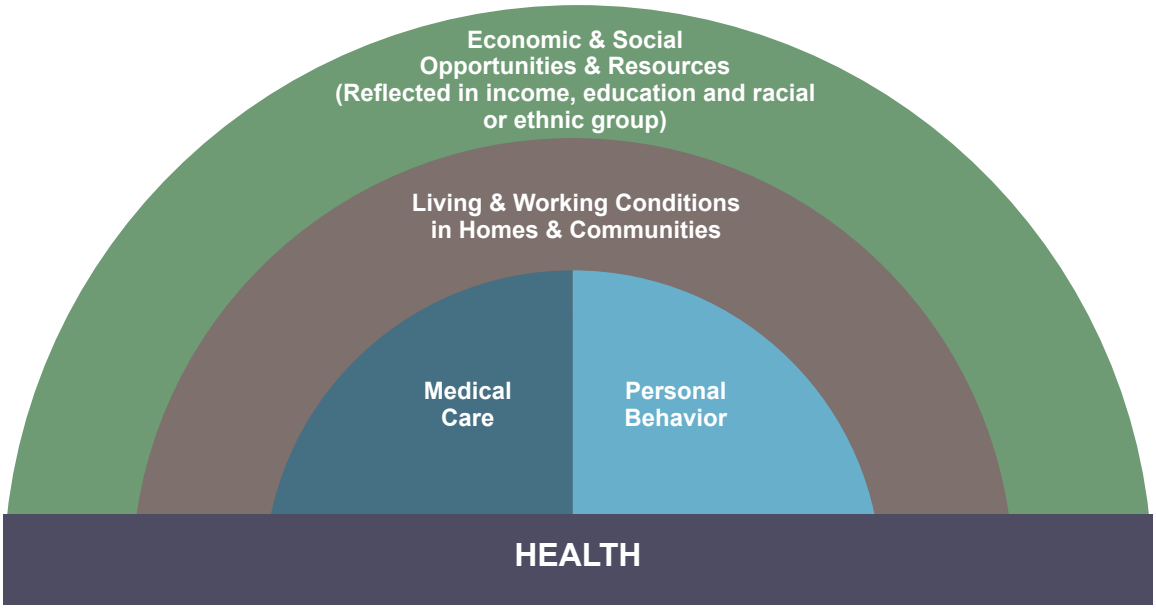
Adapted from: Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity, Linked Files, '07-'09, Source, Kaiser Family Foundation (14)



NSD: Not sufficient data. Figure does not meet standard of reliability or precision; based on fewer than 20 deaths in the numerator.

Social Determinants of Health

People who live and work in low socioeconomic circumstances are at increased risk for mortality, morbidity, unhealthy behaviors, and reduced access to health care and inadequate quality of care. Many of the underlying risk factors that contribute to health disparities and hamper equity are the result of where we live, learn, work and play, collectively known as the social determinants of health. These include social, physical environments, and health services and systems; structural and societal factors that are responsible for most health inequities. The opportunities to attain the highest level of health (i.e. health equity) are then inextricably linked to social advantage or disadvantage, a status which itself is transgenerational. Thus, the groups experiencing health disparities are more likely to remain disadvantaged without a concerted effort to achieve health equity.[3]



Source: Robert Wood Johnson Foundation, Commission on Health[40]

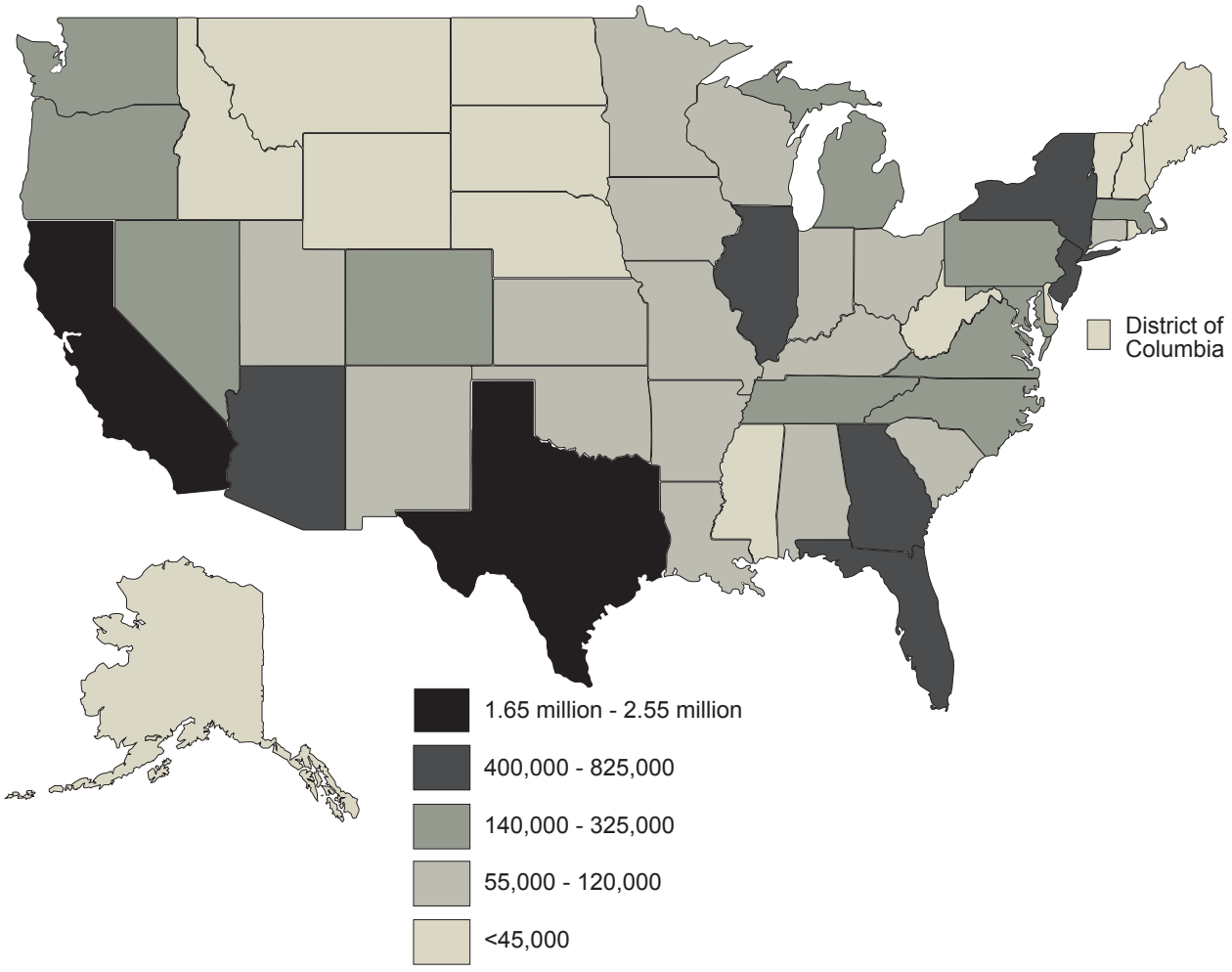
Undocumented immigrants represent an especially vulnerable portion of the population without access to healthcare given the coverage restrictions due to their legal status, and realizing that disease does not discriminate in terms of legal issues, it is important to be cognizant of those who remain without any social protection or health care access. Inequitable access to coverage jeopardizes the health and well-being of immigrant women, families and communities into the next generation, and compromises the public health of the nation as a whole.[41]

Undocumented Immigrant population in Region X States: Adapted from: "Unauthorized Immigrant Population; National and State Trends, 2010"; Estimates of Unauthorized Immigrant Population by State, Selected Years 1990-2010 (Table A3) Source: Pew Research Center (15)

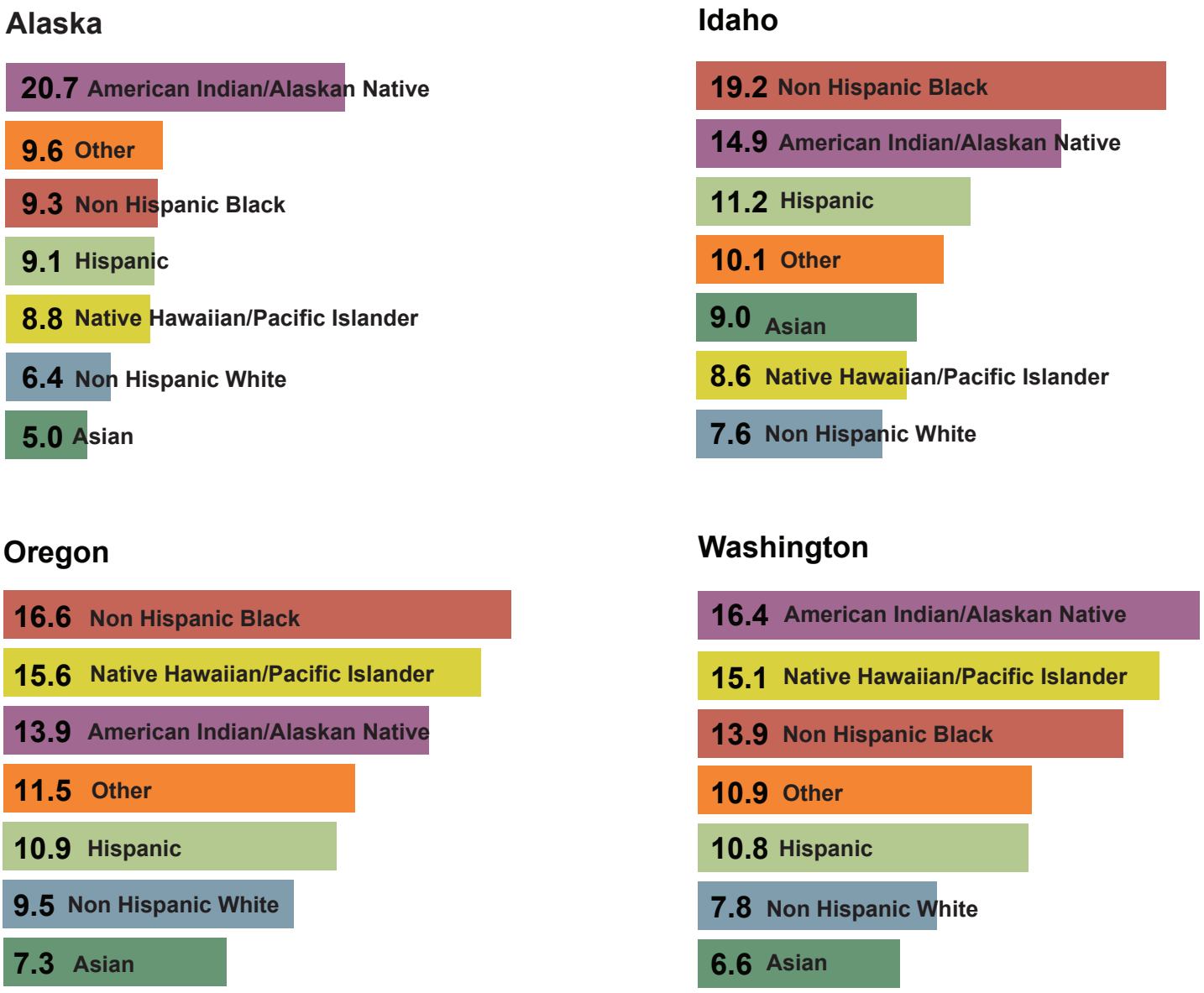
1990 - 3,525,000
2000 - 8,375,000
2005 - 11,100,000
2007 - 12,000,000
2010 - 11,200,000

	Alaska	Idaho	Oregon	Washington
1990	<5,000	10,000	25,000	40,000
2000	<10,000	25,000	110,000	160,000
2005	<10,000	30,000	140,000	200,000
2007	110,000	35,000	140,000	170,000
2010	<10,000	35,000	160,000	230,000

Undocumented Immigrant Population Share in the U.S. from: "Unauthorized Immigrant Population; National and State Trends, 2010"; Unauthorized Immigrant Share of Population- Source: Pew Research Center (16)



Percent Unemployment in Region X by State and Race, (Pop. 16+)
Source: 2007-2011 American Community Survey 5-Year Estimates S2301 (17)

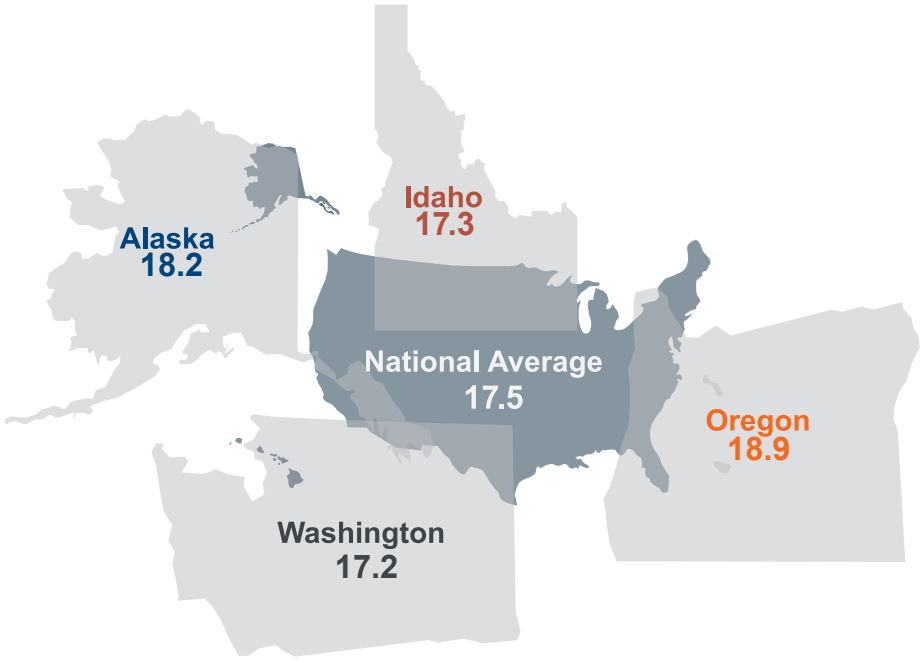


A considerable portion of the U.S. population depends on employer-sponsored health coverage, thus upon the loss of a job, an income is lost and health insurance coverage becomes compromised.[42] Historically, the unemployment rates for racial and ethnic minorities are higher than the national average and Region X exhibits the same pattern, with American Indian and Alaska natives reporting unemployment rates double those of the national average.

The Affordable Care Act (ACA) increased coverage options for the unemployed by states that implement Medicaid expansion and by subsidizing coverage purchased through the new state health insurance exchanges.

Similarly, those who are underemployed have difficulty maintaining health insurance coverage (i.e. basic access) and the lack of a stable or reliable job threatens their current health status. For example, the Kaiser Family Foundation National Public Radio Survey Long-Term Unemployment Survey reports that many of the unemployed and underemployed report negative impact on their physical and mental health. More than half of the respondents reported difficulty sleeping and weight changes of plus or minus ten (10) pounds as a result of being out of work. About 20% of these report other major health problems. Ten percent of respondents report having started a new prescription medication for a mental health problem and nine percent report having increased their alcohol and drug consumption. Almost 75% of those interviewed report at least one problem with delaying care due to inability to pay in the year preceding the survey. The care these have skipped ranged from the dental care, a medical test or treatment, not filling a prescription, and not seeking mental health care due to cost impediments. The reported rates of these problems are almost twice as high as they are among those with fulltime jobs.[43]

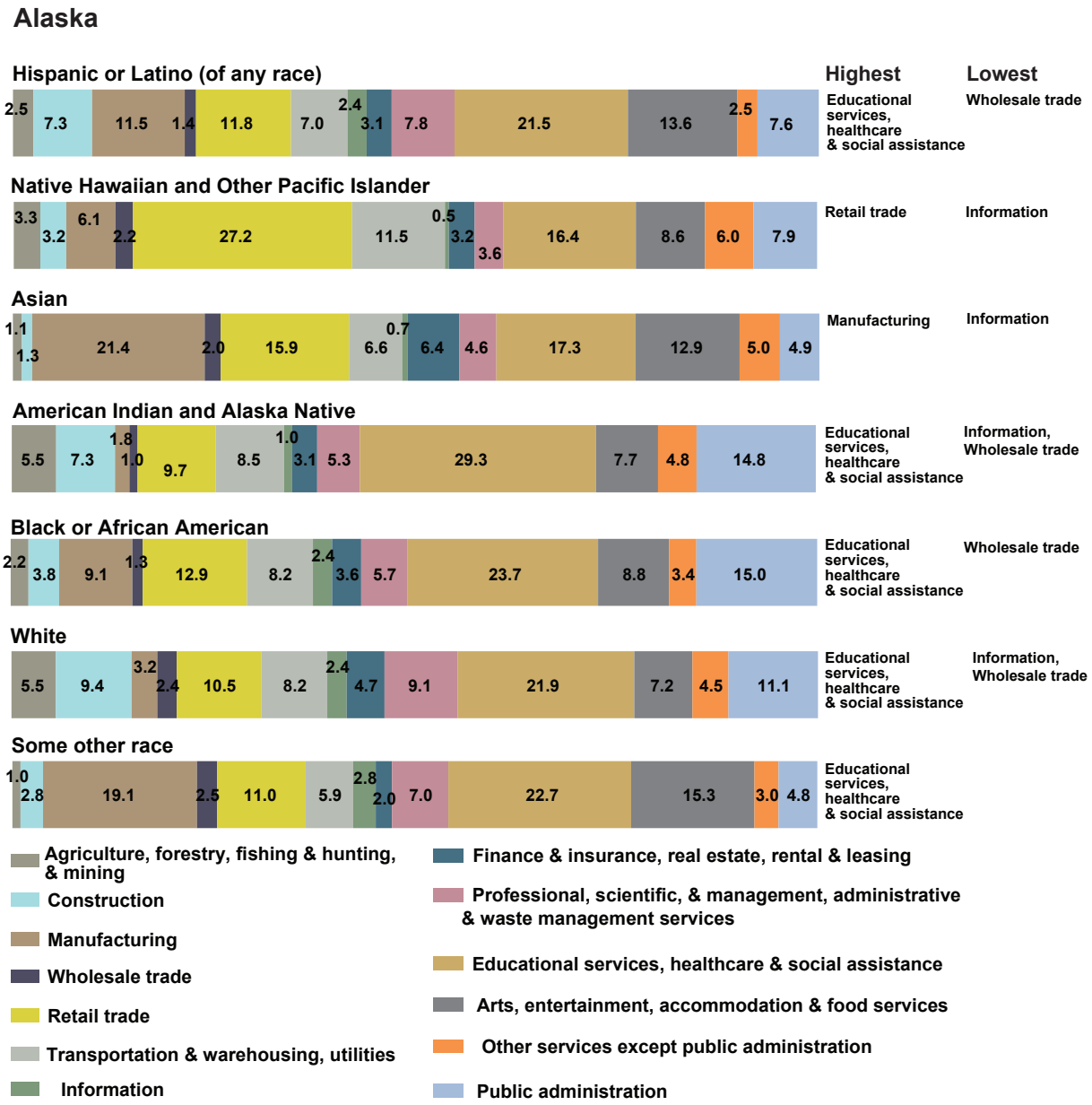
Region X Percent Underemployed by State
Source: Gallup Poll 2012 (18)



Given that health insurance is expensive, very few people can afford to buy it on their own. Most insured Americans obtain health insurance coverage through an employer. Yet, not all workers have access to employer-sponsored coverage. Those who work in low-wage jobs, blue-collar, service industry, or in small firms, are less likely to be offered employer-based coverage. Nationwide there has been a general decline in employee-sponsored insurance, yet the effects are thought to be

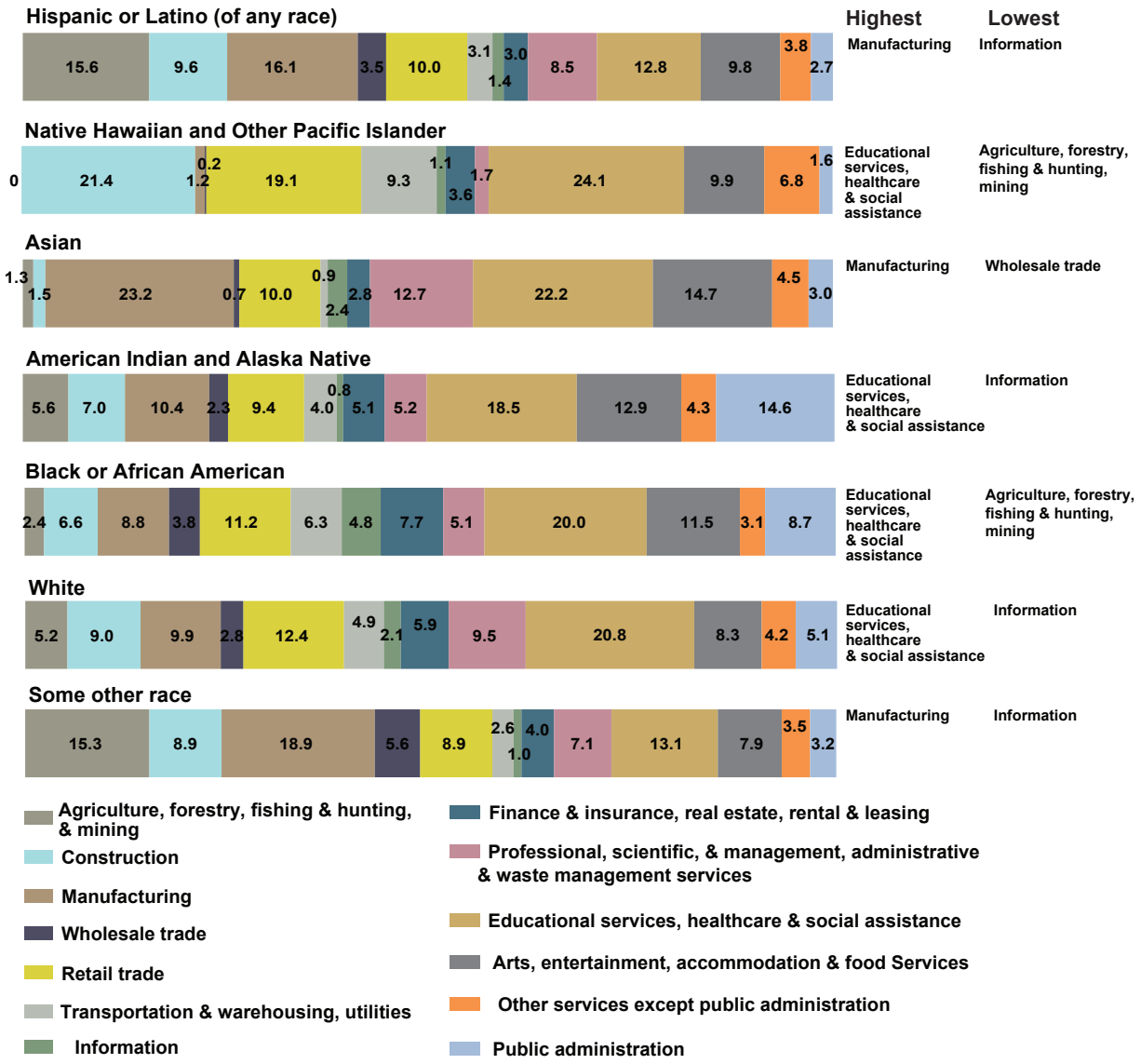
magnified for those already in vulnerable socioeconomic positions. Under the ACA, through state health insurance exchanges, subsidies and expanded Medicaid programs small employers and individuals have an opportunity to secure health insurance.[44-46]

Industry of Occupation for Employed Civilian Population over 16 years of Age by Race, Region X States
Source: ACS 2006-2010 DP03 (19)

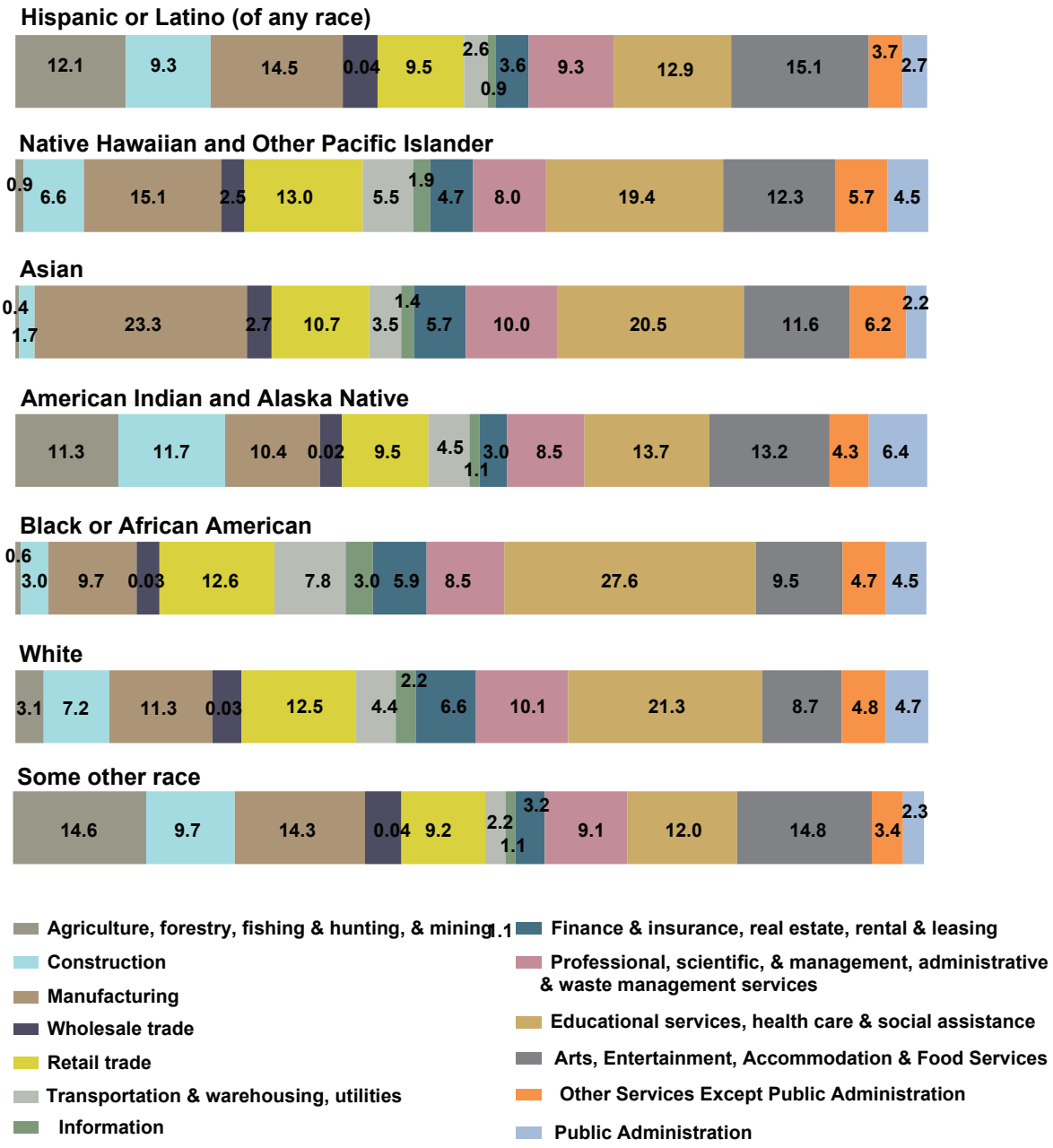


Note: Underemployment defined by Gallup Poll: The percentage of state residents who are employed part time, but want to work full time, or are unemployed (2012)

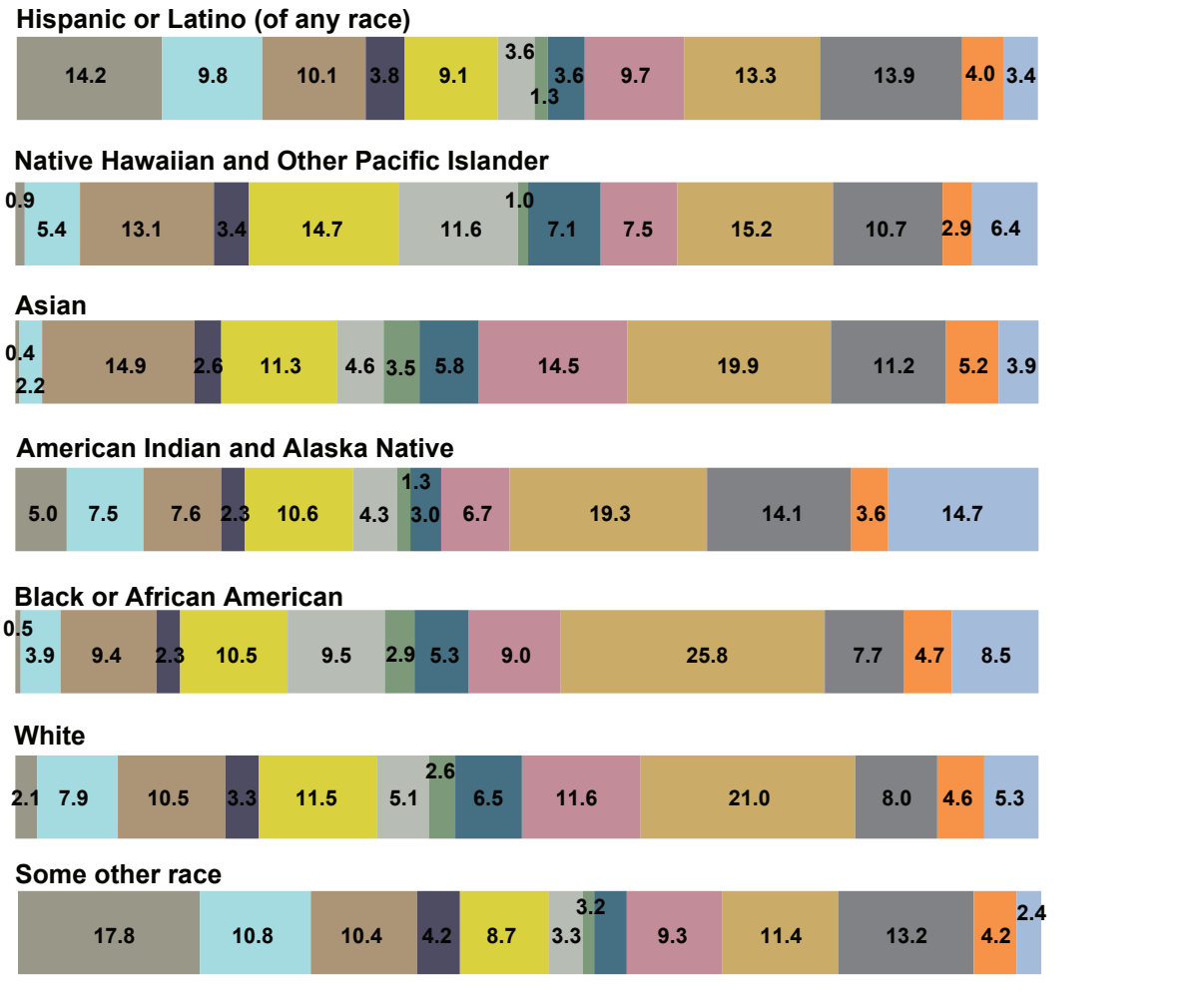
Idaho


Hispanic or Latino (of any race)
Highest
Lowest
Manufacturing
Information
15.6 9.6 16.1 3.5 10.0 3.1 1.4 3.0 8.5 12.8 9.8 3.8 2.7
Native Hawaiian and Other Pacific Islander
Educational services, healthcare & social assistance
Agriculture, forestry, fishing & hunting, mining
0 21.4 1.2 0.2 19.1 9.3 1.1 3.6 1.7 24.1 9.9 6.8 1.6
Asian
Manufacturing
Wholesale trade
1.3 1.5 23.2 0.7 10.0 0.9 2.4 2.8 12.7 22.2 14.7 4.5 3.0
American Indian and Alaska Native
Educational services, healthcare & social assistance
Information
5.6 7.0 10.4 2.3 9.4 4.0 0.8 5.1 5.2 18.5 12.9 4.3 14.6
Black or African American
Educational services, healthcare & social assistance
Agriculture, forestry, fishing & hunting, mining
2.4 6.6 8.8 3.8 11.2 6.3 4.8 7.7 5.1 20.0 11.5 3.1 8.7
White
Educational services, healthcare & social assistance
Information
5.2 9.0 9.9 2.8 12.4 4.9 2.1 5.9 9.5 20.8 8.3 4.2 5.1
Some other race
Manufacturing
Information
15.3 8.9 18.9 5.6 8.9 2.6 1.0 4.0 7.1 13.1 7.9 3.5 3.2
Agriculture, forestry, fishing & hunting, & mining
Construction
Manufacturing
Wholesale trade
Retail trade
Transportation & warehousing, utilities
Information
Finance & insurance, real estate, rental & leasing
Professional, scientific, & management, administrative & waste management services
Educational services, healthcare & social assistance
Arts, entertainment, accommodation & food Services
Other services except public administration
Public administration

Oregon

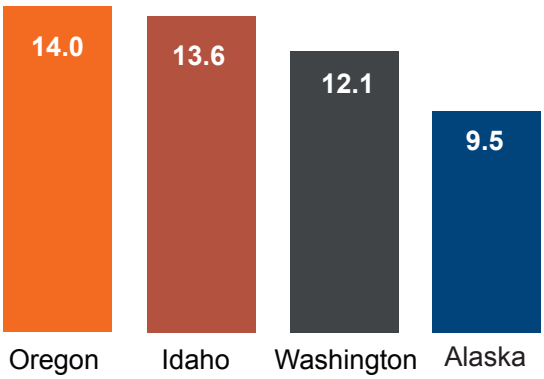

Hispanic or Latino (of any race)
12.1 9.3 14.5 0.04 9.5 2.6 0.9 3.6 9.3 12.9 15.1 3.7 2.7
Native Hawaiian and Other Pacific Islander
0.9 6.6 15.1 2.5 13.0 5.5 1.9 4.7 8.0 19.4 12.3 5.7 4.5
Asian
0.4 1.7 23.3 2.7 10.7 3.5 1.4 5.7 10.0 20.5 11.6 6.2 2.2
American Indian and Alaska Native
11.3 11.7 10.4 0.02 9.5 4.5 1.1 3.0 8.5 13.7 13.2 4.3 6.4
Black or African American
0.6 3.0 9.7 0.03 12.6 7.8 3.0 5.9 8.5 27.6 9.5 4.7 4.5
White
3.1 7.2 11.3 0.03 12.5 4.4 2.2 6.6 10.1 21.3 8.7 4.8 4.7
Some other race
14.6 9.7 14.3 0.04 9.2 2.2 1.1 3.2 9.1 12.0 14.8 3.4 2.3
Agriculture, forestry, fishing & hunting, & mining
Construction
Manufacturing
Wholesale trade
Retail trade
Transportation & warehousing, utilities
Information
Finance & insurance, real estate, rental & leasing
Professional, scientific, & management, administrative & waste management services
Educational services, health care & social assistance
Arts, Entertainment, Accommodation & Food Services
Other Services Except Public Administration
Public Administration

Washington

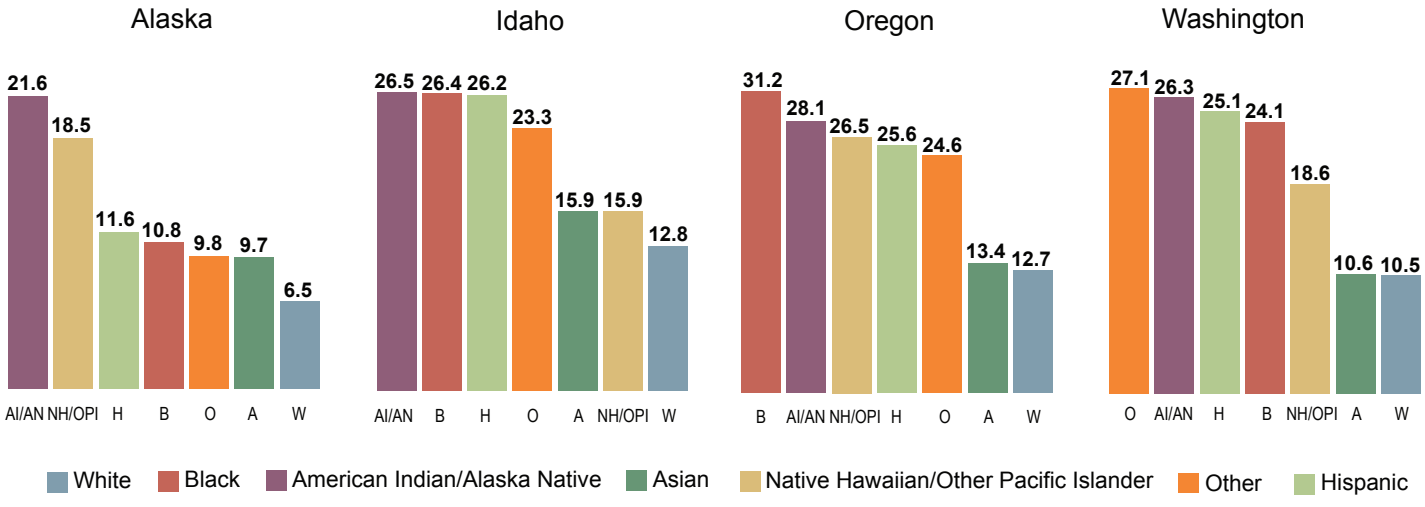

Hispanic or Latino (of any race)
14.2 9.8 10.1 3.8 9.1 3.6 1.3 3.6 9.7 13.3 13.9 4.0 3.4
Native Hawaiian and Other Pacific Islander
0.9 5.4 13.1 3.4 14.7 11.6 1.0 7.1 7.5 15.2 10.7 2.9 6.4
Asian
0.4 2.2 14.9 2.6 11.3 4.6 3.5 5.8 14.5 19.9 11.2 5.2 3.9
American Indian and Alaska Native
5.0 7.5 7.6 2.3 10.6 4.3 1.3 3.0 6.7 19.3 14.1 3.6 14.7
Black or African American
0.5 3.9 9.4 2.3 10.5 9.5 2.9 5.3 9.0 25.8 7.7 4.7 8.5
White
2.1 7.9 10.5 3.3 11.5 5.1 2.6 6.5 11.6 21.0 8.0 4.6 5.3
Some other race
17.8 10.8 10.4 4.2 8.7 3.3 3.2 9.3 11.4 13.2 4.2 2.4
Agriculture, forestry, fishing & hunting, & mining
Construction
Manufacturing
Wholesale trade
Retail trade
Transportation & warehousing, utilities
Information
Finance & insurance, real estate, rental & leasing
Professional, scientific, & management, administrative & waste management services
Educational services, health care & social assistance
Arts, Entertainment, Accommodation & Food Services
Other Services Except Public Administration
Public Administration

The two most commonly used markers of socioeconomic status in the United States are income and educational attainment. These two are positively related to most measures of health and health-related behaviors. The health of those individuals or groups with low-incomes and education levels is adversely affected. From indirect factors such as chronic stress, to direct factors such as malnutrition and exposure to the elements, these factors affect health throughout the lifetime.[47]

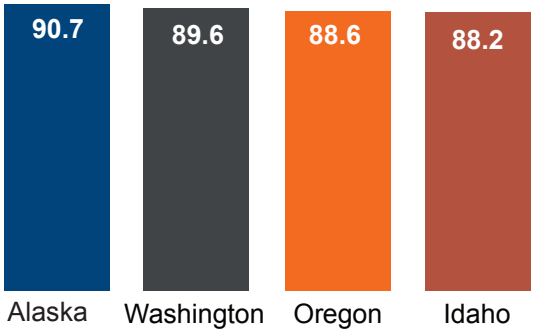
Percent of People below Poverty Level in the Past 12 Months (for whom poverty is determined)
Source: U.S. Census American Fact Finder from 2006-2010 American Community Survey
Selected Population Tables (20)



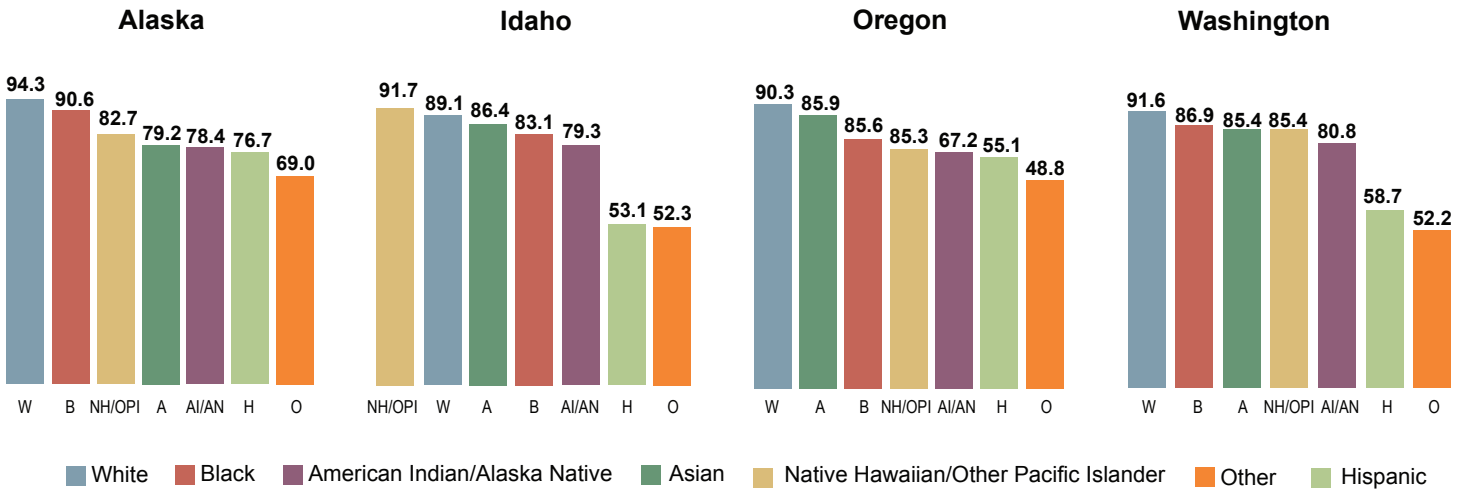
Poverty Level by Race/Ethnicity



Percent Education; Region X by State, 18 year + HS level / Equivalency,
Source: U.S. Census American Fact Finder from 2006-2010 American Community Survey Selected Population Tables (21)

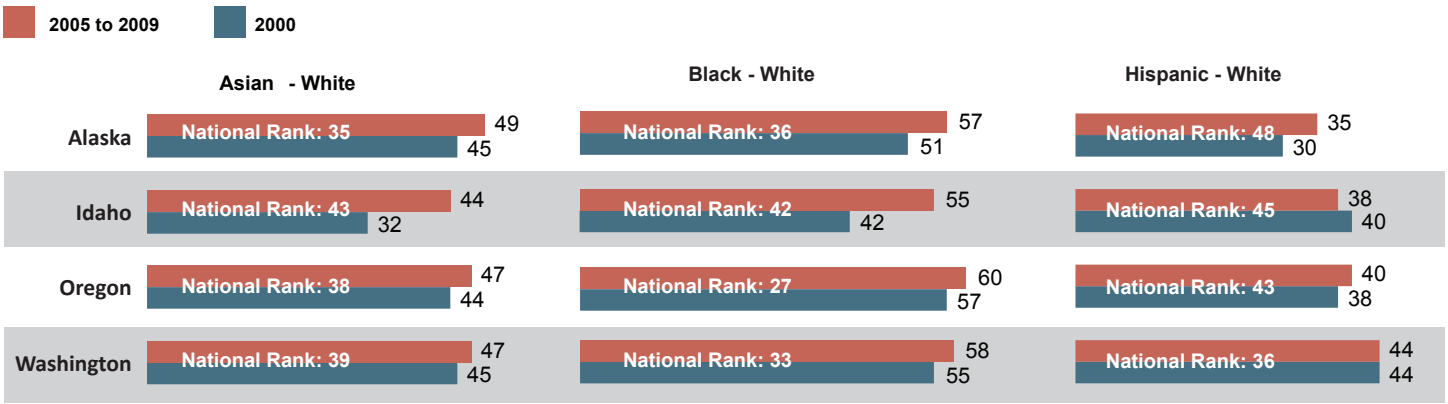


Education by Race/Ethnicity

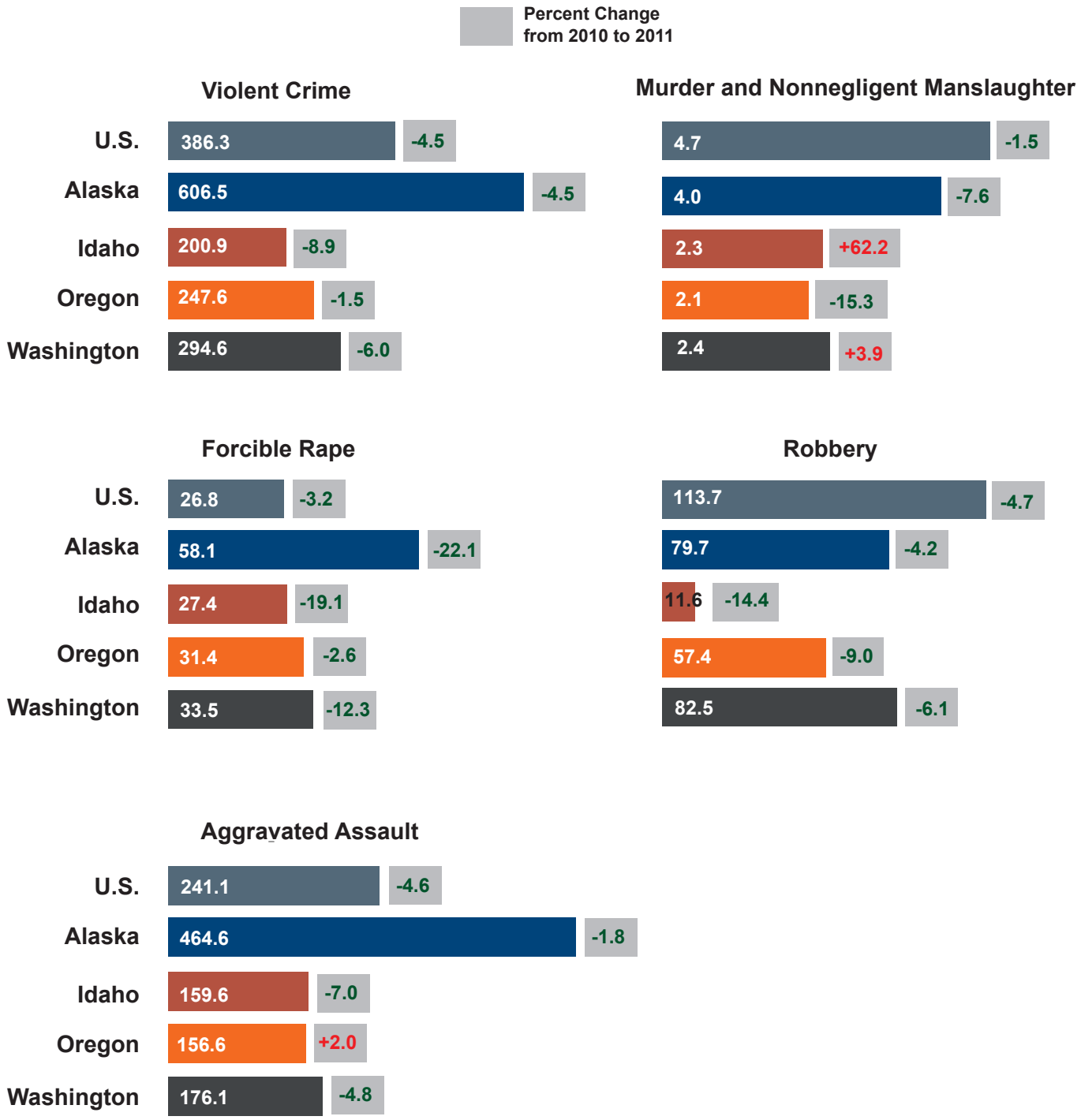


Across communities in the U.S., the degree of residential segregation remains extremely high for most African Americans. Segregation creates conditions where education and employment opportunities are inequitably distributed, which in turn impact the social and physical environments of entire communities thereby affecting health of residents. Hence racial residential segregation can lead to and exacerbate racial and ethnic disparities in health because it leads to differential experiences of "community stress, exposure to pollutants, and access to community resources."[49] Moreover, the concentration of poverty and social problems in segregated communities also creates the conditions that increase the likelihood of violence. Violence undermines people's health by causing injury, disability and premature death, especially among young people of racial/ ethnic minority backgrounds and people living in low-income areas.[50] Although in the United States and in Region X states there has been an overall decline in violent crime numbers, some areas like Idaho have seen a dramatic increase in murder and non-negligent manslaughter crimes (see chart titled Violent Crime in the United States and Region X States).[51]

Region X Residential Segregation by State
Source: Dissimilarity Index Data (22)



Violent Crime in the United States and Region X States, Crime in the United States 2010-2011
Source: U.S. Department of Justice, Federal Bureau of Investigation – Criminal Justice Information Services Division Table 4. (23)

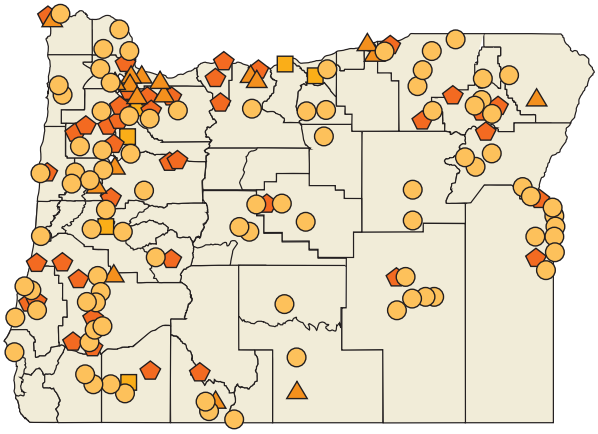


Environment

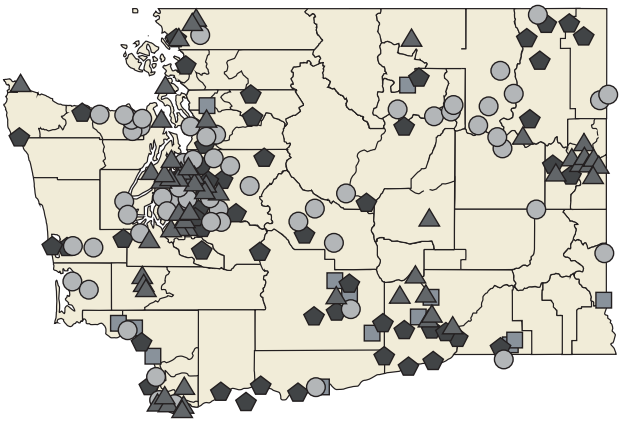
Racial and ethnic minority groups and the communities they live in are overburdened by environmental pollution. Thus, in order to address health disparities and move toward health equity, a focus on environmental justice is imperative. The geographical distribution of environmentally-relevant efforts carried out by the U.S. Environmental Protection Agency (EPA) is presented in relation to poverty and minority distributions in Region X states.

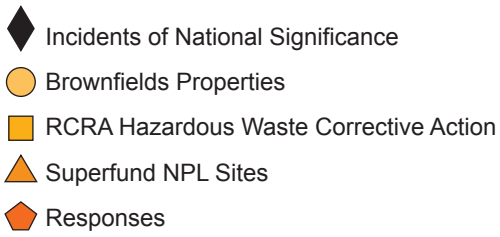
Region X: The Pacific Northwest Cleanup Sites
Source: EPA, 2013 (24)

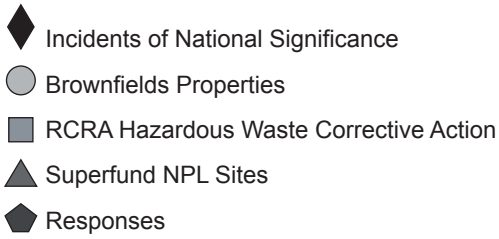
Oregon



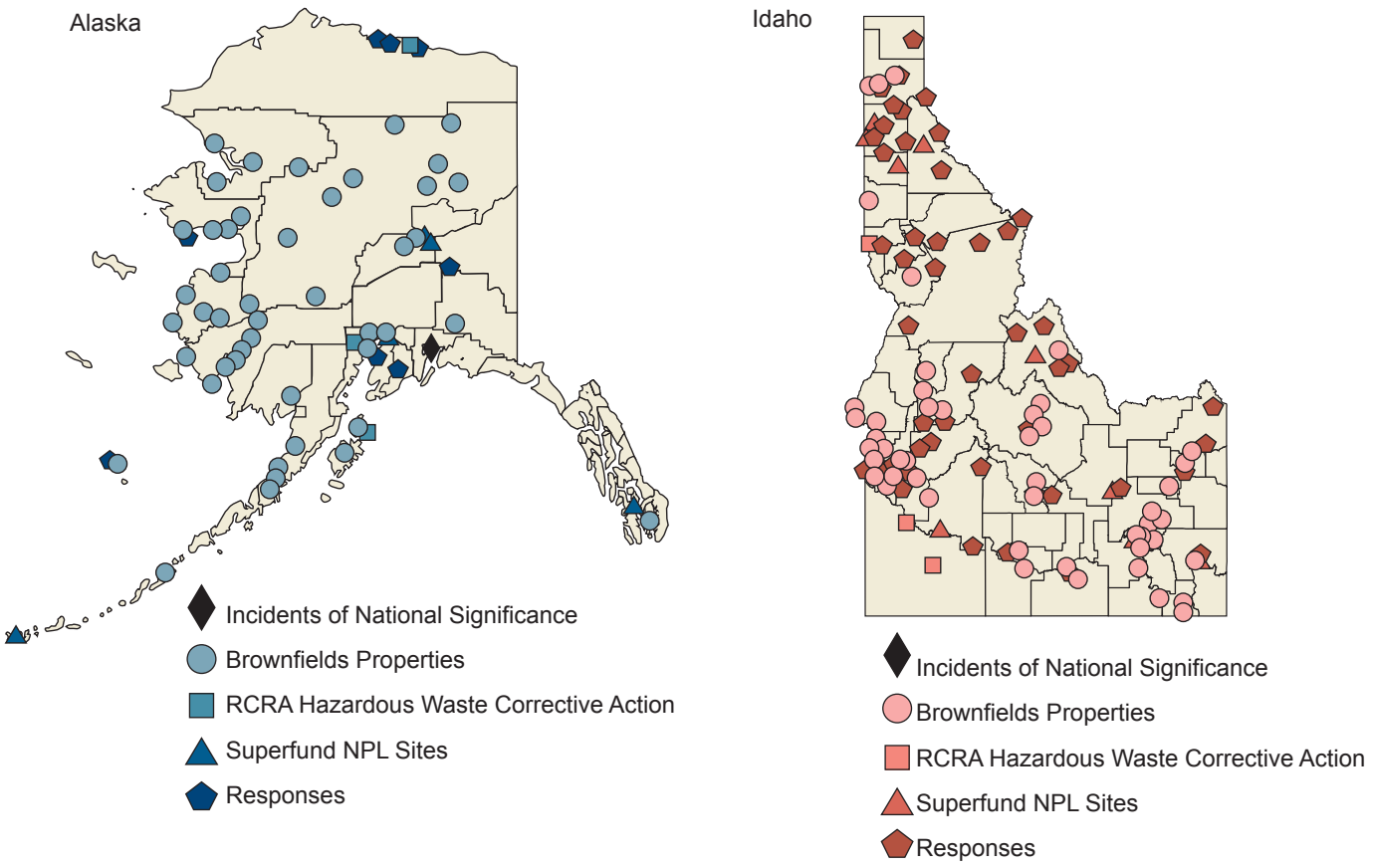
Washington







Region X: The Pacific Northwest Cleanup Sites
Source: EPA, 2013 (24)



Captions:

Hazardous Waste (RCRAInfo) Description: Hazardous waste generators, transporters, treaters, storers and disposers of hazardous waste are required to provide information on their activities to state environmental agencies. These agencies then provide the information to regional and national US Environmental Protection Agency (EPA) offices through the Resource Conservation and Recovery Act Information (RCRAInfo) System. Information on cleaning up after accidents or other activities that result in a release of hazardous materials to the water, air or land must also be reported through RCRAInfo.

Water dischargers (PCS/ICIS) Description: As authorized by the Clean Water Act, the National Pollutant Discharge Elimination System (NPDES) permit program controls water pollution by regulating sources, such as municipal and industrial wastewater treatment facilities, that discharge pollutants into waters of the United States. EPA tracks water discharge permits through the Permit Compliance System (PCS), which includes information on when a permit was issued and when it expires, how much the company is permitted to discharge, and the actual monitoring data showing what the company has discharged.

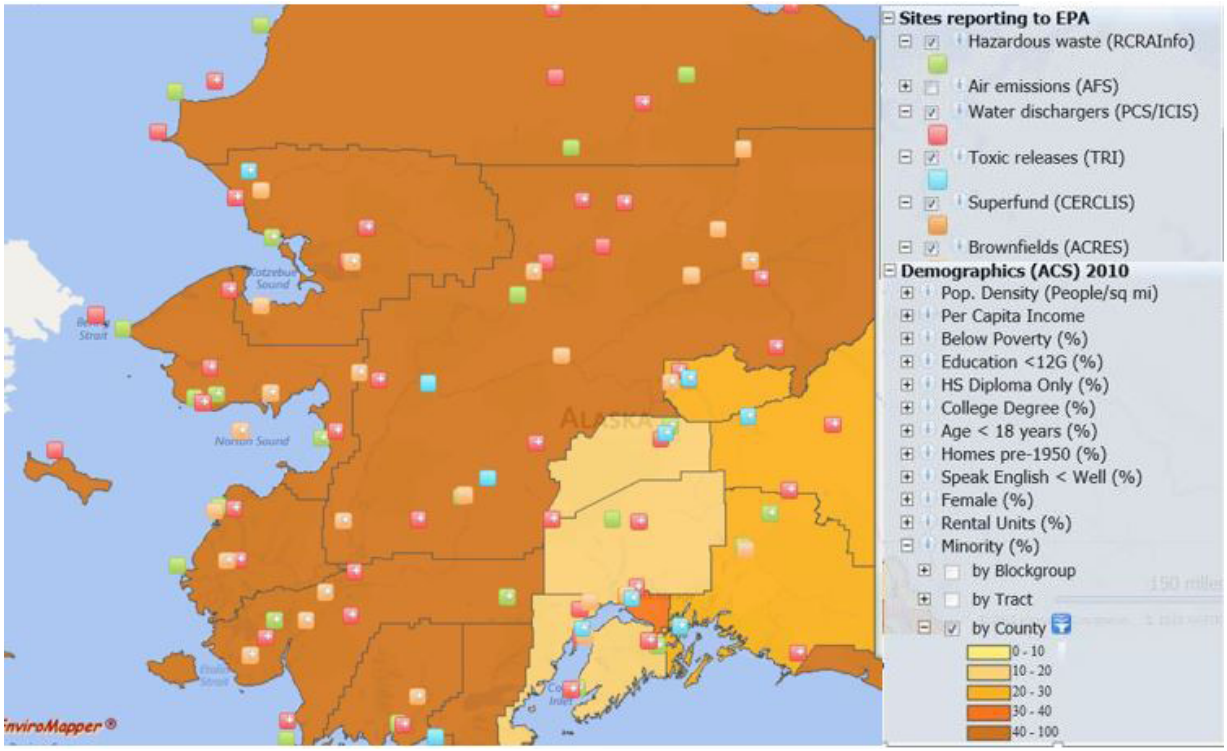
Toxic releases (TRI) Description: The Toxics Release Inventory (TRI) contains information about more than 650 toxic chemicals that are being used, manufactured, treated, transported, or released into the environment. Manufacturers of these chemicals are required to report the locations and quantities of chemicals stored on-site to state and local governments. The reports are submitted to the EPA and state governments. TRI data is provided on all facilities that have submitted a Form R or A to EPA at any time since the program began in 1987, even though the facility may or may not have submitted TRI data in the most recent reporting year. EPA compiles this data in an on-line, publicly accessible national computerized database. Also, reports are provided on information from the Risk Screening Environmental Indicator (RSEI) tool, which provides a quantitative, relative estimate of risk posed by the facility based on the chemical released and potential exposure pathways.

Superfund (CERCLIS) Description: Superfund is the federal government's program to clean up the nation's uncontrolled hazardous waste sites. The National Priorities List (NPL) is the list of national priorities among the known releases or threatened releases of hazardous substances, pollutants, or contaminants throughout the United States and its territories.

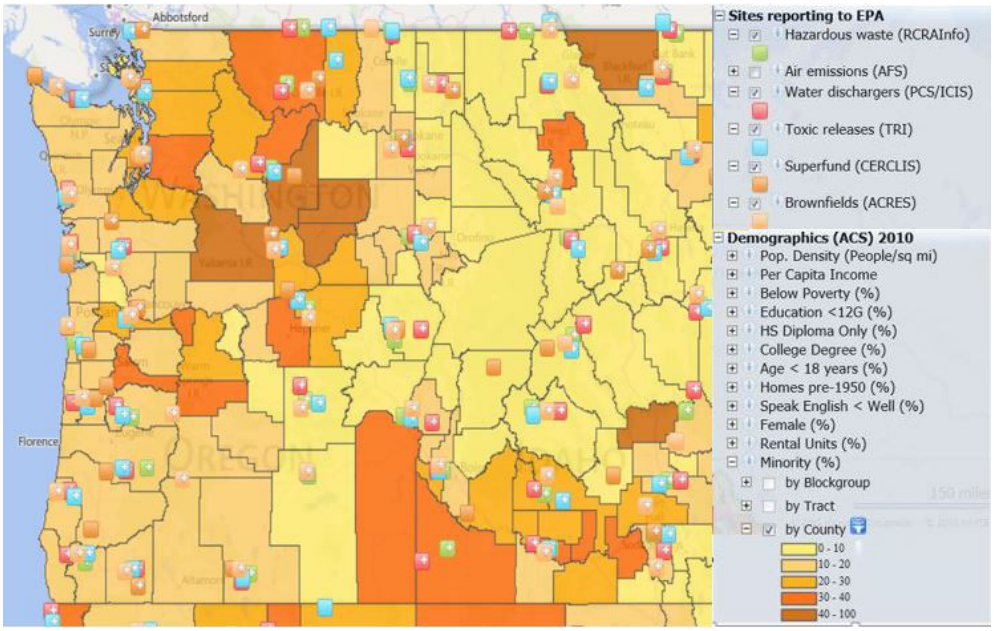
Brownfields (ACRES) Description: The Assessment, Cleanup and Redevelopment Exchange System (ACRES) captures grantee reported data on environmental activities and accomplishments (assessment, cleanup and redevelopment), funding, job training, and details on cooperative partners and leveraging efforts - a central objective of the Brownfields Program. The information in ACRES is provided at the property and grant level.

Region X: Hazardous waste, water discharges, toxic releases, superfund clean-up sites, and brownfields by Minority Population Distribution
Source USEPA, EJVIEW 2013 (25)

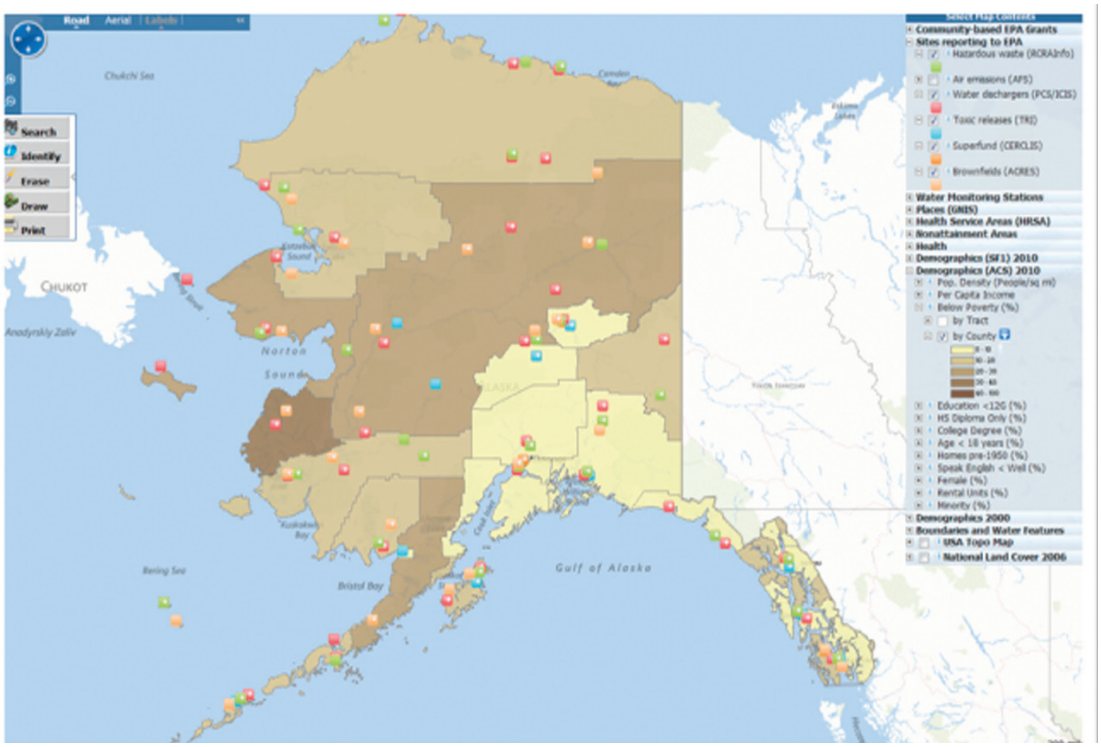
Alaska



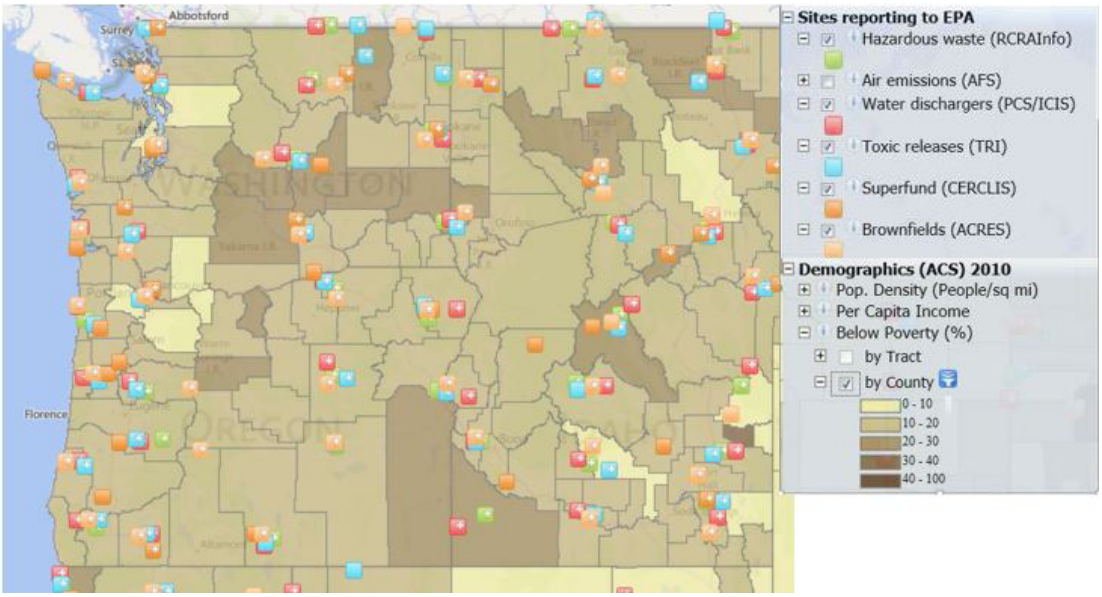
Washington, Oregon, Idaho



Region X: Hazardous waste, water discharges, toxic releases, superfund clean-up sites, and brownfields by Poverty Level Population Distribution (Source USEPA, EJVIEW 2013)



Region X: Hazardous waste, water discharges, toxic releases, superfund clean-up sites, and brownfields in Washington, Oregon and Idaho and Poverty Level Population Distribution (Source USEPA, EJVIEW 2013)



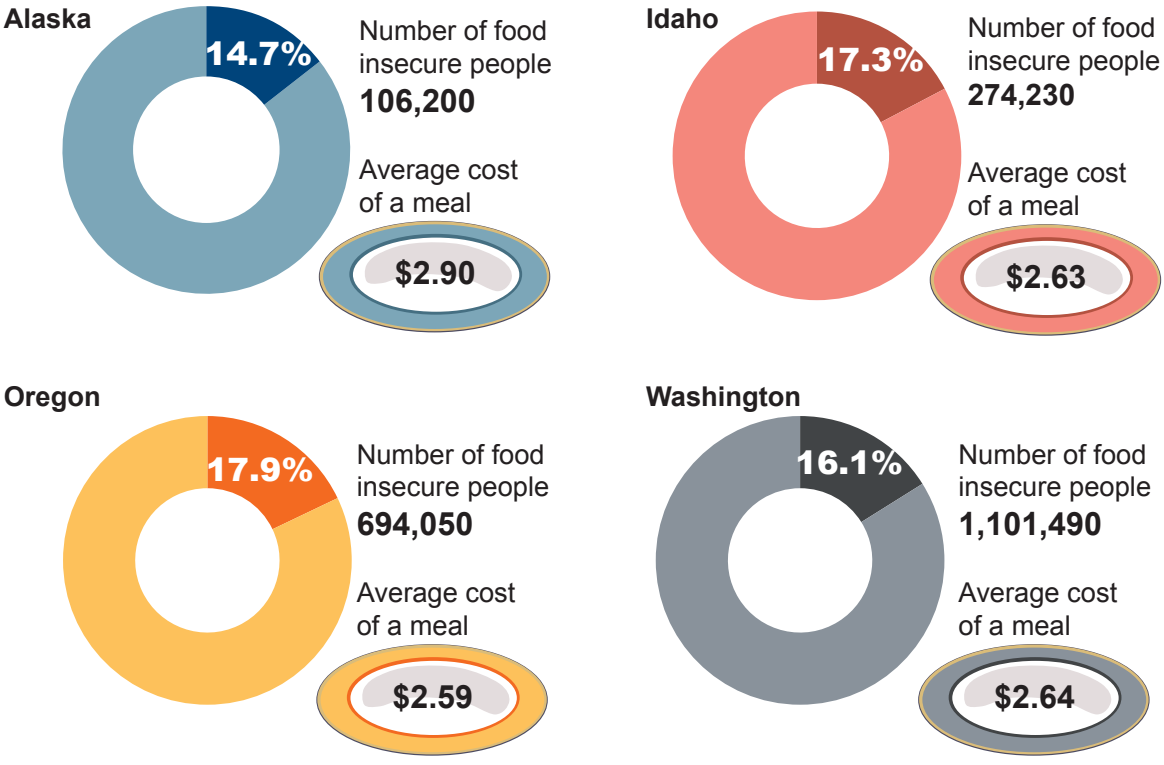
Food Insecurity

Food insecurity occurs when consistent access to adequate food is limited by a lack of money and other resources during times throughout the year. In 2012, the Economic Research Service at the United States Department of Agriculture (USDA) released its most recent report on food insecurity, indicating that 50 million (of those 17 million children) people in the United States are living in food insecure households.[52]

As poverty and unemployment increase, food insecurity increases. Among other problems, food insecure and low-income people are specifically vulnerable to obesity given the additional barriers faced such as limited resources and lack of access to healthy affordable foods, fewer opportunities for physical activity, barriers in the adoption of healthy eating behaviors, high levels of stress which may trigger anxiety and depression, higher exposure to marketing of obesity-promoting products, and limited access to care.[53]

The food insecurity and food cost information for Region X states is presented in the following graphics.

Food Insecurity and Food Cost by Region X State
Source: feedingamerica.org, 2011 (27)

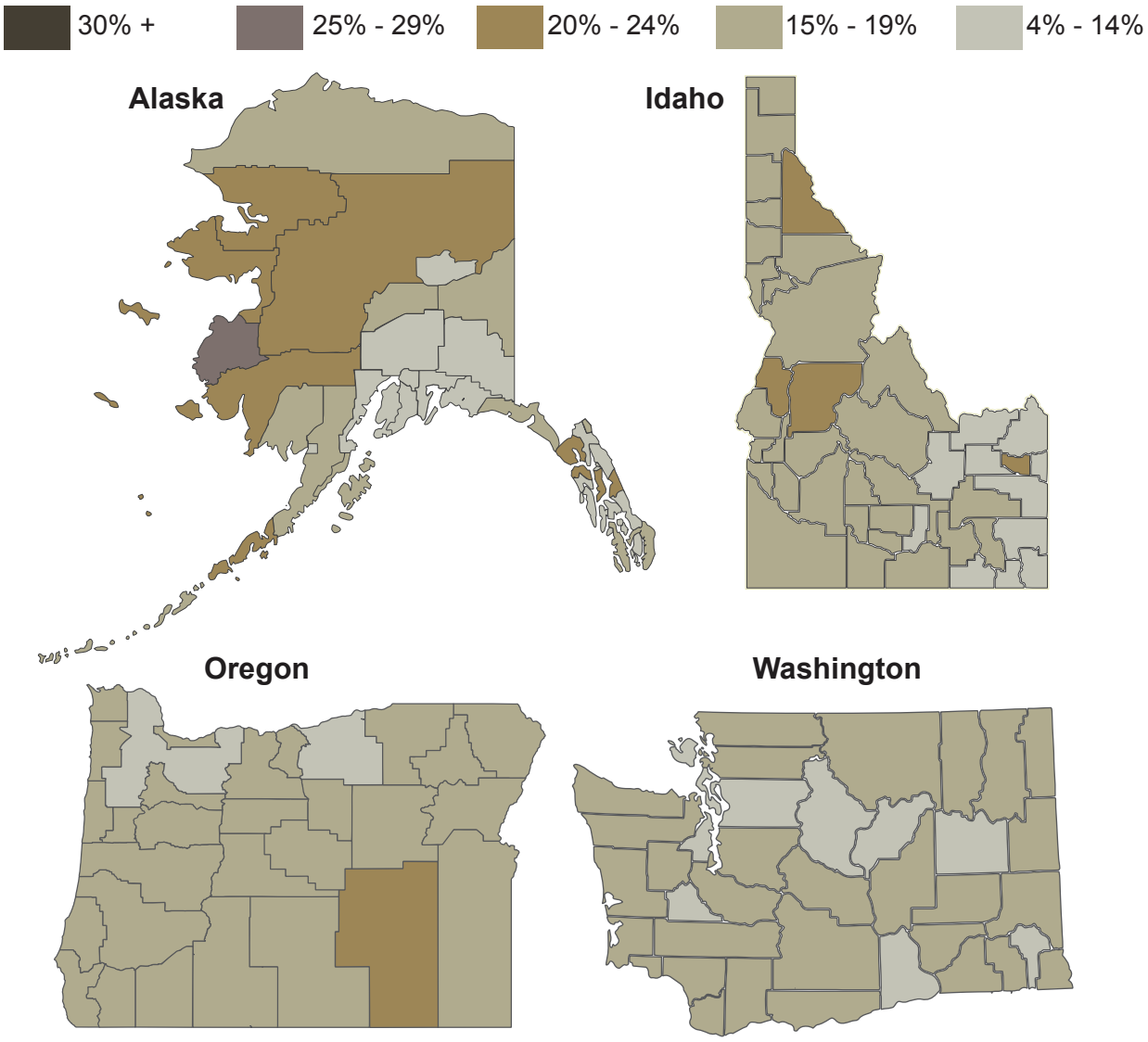


National average food insecurity rate: 16.4%

Food Deserts

Low-income neighborhoods and communities are often burdened with the inability to access affordable healthy food retailers and are consequently limited to convenience stores and small stores that offer inadequate healthy-food choices, like highly-processed foods. The neighborhoods and communities that compose these food deserts are the same that experience higher rates of diet-related diseases such as diabetes and obesity. Addressing the lack of access to healthy food is an important factor that contributes to health and to eliminating health disparities.[54]

Percentage of Population Living in Food Deserts, Region X
Source: Food Access Research Atlas, USDA Economic Research Service 2013 (28)

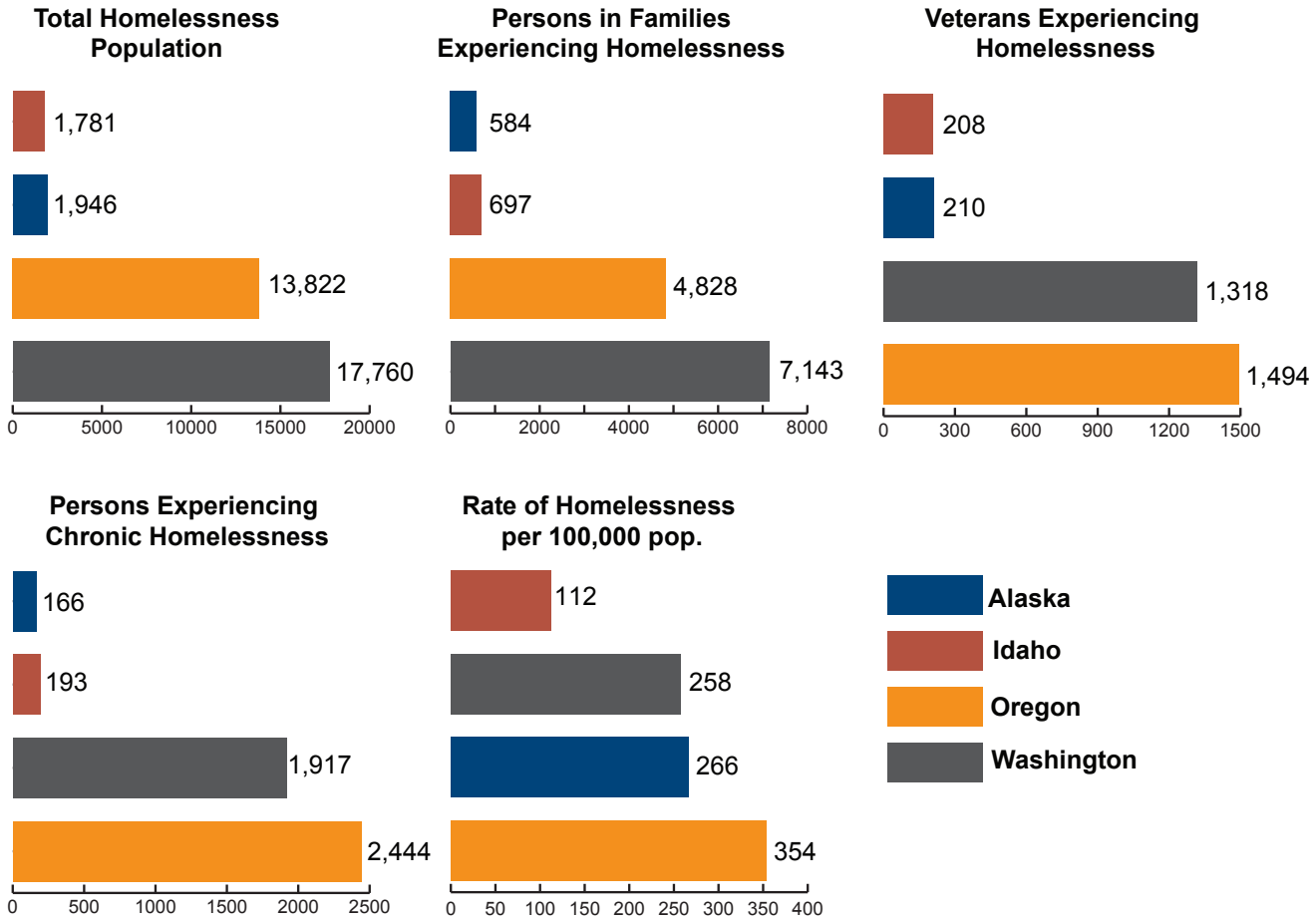


Special Populations

Homeless Individuals and Families

When addressing health disparities it is imperative to identify subpopulations that experience compounded disadvantages. The homeless population experiences poverty due to a number of factors including lack of employment opportunities, declines in public assistance, unaffordable health care, domestic violence, and mental illness. As many as 610,042 people were homeless in January 2013 and of those nearly 65% were living in emergency shelters and the remainder were living in unsheltered locations, i.e., under bridges, cars, or abandoned buildings. In Region X, Oregon had 41% of its homeless-people-in-families population living in unsheltered locations. Washington experienced a decline in the number of homeless people in families since 2012 and over the past 6 years. Idaho has a high percentage of families among their chronically homeless population (29%).[55]

Homelessness Population in Region X – Source: United States Interagency Council on Homelessness 2014 (29)



Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals

LGBT individuals encompass all races and ethnicities, religions and social classes. Unfortunately, societal stigma, discrimination, and denial of civil and human rights all play a negative role in the health disparities of the LGBT community. Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives. In order to document and address the health needs for this population data is needed. However national or state surveys do not capture gender identity or sexual orientation.[56] In the nation, about 3.5% of the population identifies as lesbian, gay, bisexual or transgender. In Region X, the percentage ranges from 2.7 to 4.9% as of January 2013.

"Do you, personally, identify as lesbian, gay, bisexual, or transgender?"
Source The Gallup Poll (30)

American Indians/ Alaska Natives

About 2% of the U.S. population self-identify as American Indian or Alaska Native (AI/AN) alone or in combination with another race, and about 1% identify solely as such. American Indian and Alaska Natives are less likely than the overall population to participate in the workforce and have higher rates of poverty. They are also more likely to report being in fair or poor health (as opposed to good, very good or excellent), being overweight or obese, and having diabetes as well as cardiovascular disease. The AI/AN population also bears a higher undue burden of mental distress and consequently experience higher suicide rates in adolescents and young adults, 2.5 times higher than the national average. Although AI/ANs who are members of federally-recognized tribes have access to the Indian Health Service, nearly one in three AI/ANs is uninsured heightening the barriers faced to attain, restore and maintain health. Even with the implementation of the ACA, half of poor uninsured adult American Indian and Alaska Natives live in states that did not engage in the Medicaid expansion and thus will continue to face access barriers.[57]

Health Status and Rates of Selected Chronic Diseases for U.S. AI/AN non elderly adults
Source: The Kaiser Family Foundation (31)

Fair/Poor Health	16	28
Overweight or Obese	64	69
Diabetes	7	11
Cardiovascular Disease	5	9
Frequent Mental Distress	38	44

Conclusion

The RHEC X has identified a number of focus areas and engaged in activities to begin to address the issues brought forth in this blueprint. The RHEC X has also identified its next steps as it moves to address health disparities in the region.

RHEC X: Focus Areas, Activities to Date & Next Steps

RHEC X is currently focused on:

- Increasing the number of minority student enrolled in nursing university departments, thereby Increasing diversity in the workforce
- Health promotion and healthcare access (e.g., ensuring Hispanic/Latino participation in policy making)
- Identifying tools and models to analyze how inequities get systemically reproduced
- Conducting an environmental scan of limited English proficiency (LEP) practice.
- The development of a LEP guide that would serve as a one stop resource where individuals in the region can find information on how to engage most effectively with refugee, immigrant and non-English speaking residents. This will include definitions, best practice and compliance links reflecting LEP, with a strong focus on translation and interpretation through a cultural lens.
- Updating the RHEC X website to include best and promising practices in the region.

The RHEC X members have been engaged in a number of activities that embody the mission and vision of the RHEC as well as further NPA. Some of the presentations conducted or coordinated by RHEC members include:

- Partnered in a student-centered community event, “Changing the Course of Health through Mentoring”, at the University of Washington.
- “Empowering Community Members to Advance Health Equity – Building Capacity through Innovative Training Models”. This national webinar was a collaborative with ASTHO and included presentations on Oregon’s DELTA program and Idaho’s Community Health Advisor program.
- “An Introduction to the NPA and Regional Health Equity Councils. What does it mean for minority health and how can you get involved?” which was presented at the NAACP Tri-States Conference (Idaho, Nevada & Utah).
- The presentation of the Equity Empowerment Lens Webinar hosted by the Washington Health Association, which included a separate presentation on a countywide approach to equity and social determinants of health.
- Presentation to the America College of Health Executives, Oregon chapter regarding the RHEC and its efforts.
- Efforts have been made by RHEC members to address the questions to the community regarding the ACA and the populations (i.e. the undocumented immigrants) that it does not cover.

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